



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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APPLICATION/ANNUAL REPORT AND FIVE-YEAR NEEDS ASSESSMENT

I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT

1.1 Letter of Transmittal ()

1.2 Face Sheet (SF 424) enclosed and signed ()

TABLE OF CONTENTS

I.	COMMON REQUIREMENTS OF THE APPLICATION AND ANNUAL REPORT	
1.1	Letter of Transmittal	
1.2	Face Sheet	
1.3	Table of Contents.....	3
1.4	Overview of the State.....	5
1.5	The State Title V Agency	10
II.	REQUIREMENTS FOR THE ANNUAL REPORT	
2.1	Annual Expenditures.....	34
2.2	Annual Number of Individuals Served.....	35
2.3	State Summary Profile.....	35
2.4	Progress on Annual Performance Measures.....	39
2.5	Progress on Outcome Measures.....	78
III.	REQUIREMENTS FOR APPLICATION	
3.1	Needs Assessment of the Maternal and Child Health Population.....	84
3.1.1	Needs Assessment Process.....	84
3.1.2	Needs Assessment Content.....	92
3.2	Health Status Indicators.....	155
3.3	Annual Budget and Budget Justification.....	162
3.4	Performance Measures.....	163
IV.	REQUIREMENTS FOR THE ANNUAL PLAN	
4.1	Program Activities Related to Performance Measures.....	169
4.2	Other Program Activities.....	223
4.3	Public Input.....	225
4.4	Technical Assistance.....	225
V.	SUPPORTING DOCUMENTS.....	227
5.1	Glossary	
5.2	Assurances and Certifications	
5.3	Other Supporting Documents	
5.4	Core Health Status Indicator Forms	
5.5	Core Health Status Indicator Detail Sheets	
5.6	Developmental Health Status Indicator Forms	
5.7	Developmental Health Status Indicator Detail Sheets	
5.8	All Other Forms	
5.9	National “Core” Performance Measure Detail Sheets	
5.10	State “Negotiated” Performance Measure Detail Sheets	
5.11	Outcome Measure Detail Sheets	

1.4 Overview of the State

The people of Massachusetts enjoy better overall health status and access to health care services than in many other states. These benefits derive in significant part from favorable natural resources, relatively high levels of income and education, a thriving economy, a history of strong legislative support for funding health and social service programs, and strong public health leadership both in state government and in community and advocacy organizations. The Bureau of Family and Community Health (BFCH) is the Title V program. As such, it plays a key role in assuring access to comprehensive multidisciplinary service networks and systems. It emphasizes public/private partnership and collaboration in building such networks and systems. A major focus is on the at-risk and underserved populations of the Commonwealth whose health status and access to care are compromised.

Massachusetts: Geography, Demographics, and Economy

Massachusetts is the sixth smallest state in landmass, measuring just 150 miles in its longest direction. However, it ranks 13th in population and is relatively dense (768 people per square mile) and urbanized, with just 15.7% of residents living in rural areas. Ten percent of the population (559,379 in 1997) lives in Boston, the state capital and largest city, and half lives within the belt highway that defines metropolitan Boston. The next two largest cities are Worcester in central Massachusetts (pop. 167,507) and Springfield in the west (pop. 148,178). There are also numerous smaller cities, many of which are historically based in the mill industries. Rural areas predominate in the western section of the state, where the Berkshire Mountains separate many small towns with limited health services. Franklin County in the west, the only completely rural county, has just 79 people per square mile. Farming is still a significant industry in rural areas, with 6100 farms on 570,000 acres. Population has shifted somewhat over the past decade with an increasing number of people locating to smaller towns and suburbs.

In eastern Massachusetts, there are 1500 miles of coastline on the Atlantic Ocean. Two islands, Nantucket and Martha's Vineyard, are located 16 and 5 miles off the Cape Cod shore. With a combined year-round population of approximately 20,000 and a summer population triple that size, these rural island communities face particular challenges in meeting their health care needs.

The entire state is incorporated (there are no frontier areas) into 351 cities and towns, which are the functioning units for most local services, including public health, below the state level. There are no county health systems and other county functions, such as courts and corrections, are being converted to state administration.

Massachusetts has an estimated population of 6,227,622 (1997), of whom 1,618,141 (26%) are children and youth through 19 years of age and 1,464,584 are women ages 15-44. The state's overall population has grown slowly in the 1990s (up 2.2% since 1990) and is projected to continue in this pattern through the next decade. However, the racial and ethnic demographics of the population are

changing rapidly within this overall pattern. In 1997, the general population was 4.6% Black, 4.8% Hispanic and 2.3% Asian, and resident births in 1998 were 6.8% Black, non-Hispanic, 10.6% Hispanic, and 4.6% Asian. Between 1990-2000, both Hispanic and Black population growths are projected to have risen 41%. The predominant Hispanic ancestry groups in Massachusetts are Puerto Rican and Dominican.

Estimates of immigrants and refugees vary widely due to the lack of firm data on recent immigration trends and inherently difficult issues in counting changing populations with language and cultural isolation. Massachusetts has the 7th largest refugee and immigrant population in the United States, according to the 1990 US census, which reports 10% of residents as foreign-born. The BFCH Office of Immigrants and Refugees estimates, based on information from knowledgeable community sources in areas with significant newcomer populations, that the current overall numbers of immigrants and refugees may be one and half times that number. Southeast Asian, former Soviet Union residents, Brazilians, and refugees from the Balkans are among the fastest growing populations. One community expert has estimated a 490% increase in the Asian population in Worcester alone in the past decade. It is also reported that Lowell has the second largest Cambodian population in the country, second only to California.

State Department of Education data regarding numbers of students whose primary language is not English (PLINE) are useful indicators of overall immigrant patterns. These data indicate that in 1999, 13% of all students grade K-12 have a primary language other than English, a percentage that continues to rise. Thirty-four towns and cities have greater than 10% of their student body whose primary language is not English, and five communities have greater than 40%. The dominant languages are Spanish (51% of total PLINE), Portuguese (9.7%), Khmer (5.9%), Chinese (5.6%), and Vietnamese (4.7%). Statewide, there are more than thirty different languages spoken by a significant number of students in at least one school system.

Massachusetts is a comparatively wealthy state and has benefited greatly from the strong economy of the late 1990s. There is a diversified economic base that includes health care, education, finance, insurance, telecommunications, computer technology, biotechnology, tourism, farming, and fishing. The state has the highest percentage of college-educated individuals and the third highest annual average pay (1998) in the nation. Unemployment has steadily declined in the past five years and is currently (May 2000) at a record low of 2.5% (US = 4.1%). While all regions of the state have benefited, there is still disparity in poorer urban and rural areas. Poverty rates, while lower than the national average and declining, have not decreased proportionate to the overall economic upswing. In 1997, 8.9% of the overall population and 13.2% of children under 18 lived in poverty while 21% of the population were in families with incomes below 200% of the federal poverty level (FPL). The highest concentrations of poverty in the state are found in neighborhoods of urban areas.

In fact, the actual financial status of a low-income family in Massachusetts is poorer than in many other states due to the high and rising cost of living, particularly housing. The Urban Institute's 1996 National Survey of American Families found that Massachusetts families below 200% FPL had statistically significant lower rates than the national average for parental employment and that 39% had difficulty paying their mortgage, rent and utility bills compared to 28% nationally. Homelessness and food pantry use have been rising steadily in the state even in the face of the record high employment rates. It is generally acknowledged that steeply rising housing costs are a downside to the strong economy that have disproportionately affected low-income and working class families. Massachusetts has the third highest overall housing costs in the country. Vacancy rates for apartments in many cities are running at less than 3%, contributing to rising rental fees. Data from the BFCH's welfare transition assistance program, FOR Families, shows that housing assistance is the most common reason that former TANF families are referred to them, followed by food insecurity.

It is estimated the number of homeless families more than doubled to an estimated 10,000 from 1990 to 1997 (University of Massachusetts, 1998), a significantly higher rate of increase than for homeless individuals. Family shelters funded by the Department of Transitional Assistance, the state welfare agency, are running at full capacity, with less than a 2% vacancy rate in state FY99. A survey of Boston homeless individuals found that 64% of the children in shelters were under six years old and that domestic violence was present in 40% of the mothers with children. The state Executive Office of Administration and Finance conducted a review of homelessness in 1999 and concluded that "while there are other problems associated with family homelessness, such as domestic violence, the basic problem for families is that housing costs in several parts of the Commonwealth have risen dramatically in recent years."

Project Bread, an umbrella organization that supports food pantries, soup kitchens and related hunger relief efforts in Massachusetts, reports that the use of food pantries by families is rising, and that their hotline answered nearly 35,000 calls last year from people about finding resources to help feed their families. Many food pantries attribute this apparent rise in food insecurity to the trade-off that families are making between housing costs and food.

Massachusetts: Health Insurance and Health Services

Massachusetts recognized the need to provide health insurance as a first step in assuring access over 15 years ago. Over this period of time, the Title V program has worked closely with the state Medicaid agency (Division of Medical Assistance / DMA) to develop a simplified, seamless enrollment process for both pregnant women and children.

Most of our data on the insurance status of women and children predate the most recent efforts to enroll children and their parents in the expanded MassHealth (Medicaid) program, which includes Title

XXI/Children's Health Insurance Program (CHIP). Available data from several sources show clearly that lack of insurance among children is concentrated in low-income populations, and that recent expansion in coverage are having an impact:

- The US Census Bureau Current Population Survey, based on a three year trend from 1995-97, show that overall 9.4% of all children were uninsured, with 15.5% of children at or below 200% FPL and 6.5% of more affluent children lacking health insurance.
- A 1998 state survey estimated overall lack of insurance at 8.1%, down from 11.4% in 1995. Among children, 12.3% of those who were low-income were uninsured, while only 1.9% of more affluent children lacked health insurance.
- The Urban Institute's National Survey of America's Families (with 1996 data) shows similar results for children: 12.8% of low-income children lack insurance, while only 2.3% of others do.
- Preliminary 1999 state Behavioral Risk Factor Survey data suggest that the overall level of insurance coverage for children under 18 may be as high as 97.3%, but with approximately 14% of children in minority households with a parent without a high school degree being without insurance. [This survey should not be compared directly with the others and this is the first time that questions specific to child health insurance coverage have been included in it. These are the only survey data currently available that were collected after Title XXI expansion went into effect.]

CHIP is best understood in Massachusetts as part of a comprehensive, combined plan for the state's families, which includes expanded and new MassHealth (Medicaid) programs and two components - Healthy Start and Children's Medical Security Plan (CMSP) – operated by the Title V program in close coordination with MassHealth. Massachusetts has implemented CHIP as part of MassHealth (with a private insurance component that supports premium payments for eligible families to discourage 'crowd-out') in a seamless integration with expanded and revised eligibility criteria and streamlined enrollment procedures that were approved as part of its HCFA 1115 waiver. The combined MassHealth and DPH programs have been very successful in increasing enrollment of children. See section 3.1.2.3 in the Needs Assessment for a more detailed discussion of health insurance programs and changes over the last several years.

The Massachusetts health delivery system depends on public-private partnerships for the delivery of all services, including MCH services. The vast majority of community prevention, primary care and specialty services are provided by private health care providers and community-based non-profit organizations. Within each city and town, local government is responsible for developing and enforcing environmental and sanitary codes. Some larger health departments also provide screenings, public health and school nursing services, and other traditional public health core functions. MDPH contracts with a

wide range of these providers (both private and public), using a competitive bid process, for most of its community-based services. All vendors with contracts with the MDPH must report on uniform performance measures that assure a cultural competent, family-centered, community-based approach. All are required to participate in the health improvement processes of their local Community Health Network (CHNA). MDPH also actively collaborates with local health departments through a Local Health Advisory Group and Local Health Institute to improve their infrastructures and provide training and technical assistance.

There are approximately 50 community health centers (CHCs) with over 100 service locations that are major providers of primary care and specialty services to at-risk and underserved populations; MDPH contracts with them for a wide range of primary care and MCH services. There are also a wide variety of other community-based health and human service agencies that provide other MCH services such as early intervention, WIC, home visiting, teen pregnancy prevention, family planning, and health promotion. Title V purchased services are integrated into MDPH primary care, school health, and CHC programs to assure a multi-disciplinary, comprehensive, family-centered care model whenever possible. Community health centers are the major safety net providers in the state, especially for the non-English-speaking, minority, uninsured and MassHealth (Medicaid) populations. In areas of the state without CHCs, providing comprehensive, multi-disciplinary services becomes more difficult; the Bureau therefore works actively to support the development of additional CHCs or to promote access through other community-based

Over half of the population is enrolled in a managed care plan; these plans include capitated HMOs, preferred provider network systems, and other forms of MCOs. Private physician practices are widely distributed across the Commonwealth and a major source of medical care for children. The vast majority are part of one or more MCOs. Collaboration with these providers is critical in assuring care for children, including children with special health needs. They are key in providing on-going preventive and acute care and linkage to specialty services, especially for BFCH programs such as Healthy Start and Children's Medical Security Plan (CMSP). The BFCH and other MDPH Bureaus, in addition, work with these providers in relation to the identification of gaps in health care resources, and in relation to training, technical assistance and development of educational materials. MassHealth, the state Medicaid program, also operates through contracting with the existing health care delivery system in the Commonwealth. Almost 1,800 medical sites (including private physician practices) and all CHCs and hospitals are participating providers. CMSP utilized the same network of providers thus assuring continuity of providers if a child moves from MassHealth to CMSP or vice versa.

Title V in Massachusetts

The philosophy of the Massachusetts Title V program, is that in order to fully address the health needs of mothers and children, systems, programs and services need to consider the health of the entire family, including the community. In the Bureau of Family and Community Health, all systems and programs begin with this philosophical approach -- addressing the needs of women, children and youth, including those with special health needs, within the context of the family. The state's philosophy simply stated: "Healthy families lead to healthy children."

MDPH collaborates as a sister agency within the cabinet-level Executive Office of Health and Human Services (EOHHS) with other state agencies in regular meetings, cross-agency program development, workgroups and special taskforces. Other agencies within EOHHS include the Department of Transitional Assistance (welfare), the Division of Medical Assistance (DMA), the Department of Social Services (child welfare), the Office of Child Care Services, the Department of Mental Health, the Department of Mental Retardation, Department of Youth Services, and the Division of Health Care Finance and Policy. Agencies outside EOHHS with which we actively collaborate include the Commission for the Blind, Commission for the Hard of Hearing, the Department of Education and a number of Public Safety agencies. Massachusetts is trying to maximize systems building and minimize the potential confusion brought by multiple state plans, service networks, and community coalitions, by coordinating the development of these activities and structures across state programs.

The Assistant Commissioner of BFCH, who is the Title V administrator, holds a senior leadership position with MDPH and is integrally involved in collaborations and decision-making regarding both internal and cross-agency program development that affects MCH populations. The Assistant Commissioner also collaborates with and seeks input from professional organizations, consumer representatives, advocacy groups, and community providers and participates on multiple committees and taskforces addressing MCH issues in the state.

Our new MCH Priorities and State Performance Measures (see Sections 3.2.1 and 3.4 below) clearly reflect the systems development and partnership philosophies articulated above and have been developed with the Massachusetts health care system context in mind.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Bureau of Family and Community Health (BFCH) in the Massachusetts Department of Public Health (MDPH) is the Title V Agency for the Commonwealth of Massachusetts. The Department of Public Health is part of the Executive Office of Health and Human Services. (See the State Government, State Health Agency, and State Title V organizational charts in Section 5.3.1.) A programmatic overview of

the Bureau and its Divisions is provided in Section 1.5.1.2 below. The Department and the Bureau underwent some reorganization during FY00. At the Department level, a new position, Associate Commissioner, Program and Prevention was created. Deborah Klein Walker, our previous Title V director, fills that position. The Bureau of Family and Community Health reports to the Associate Commissioner. Within the Bureau, Sally Fogerty is now the Bureau Director and Assistant Commissioner. Her previous responsibilities as Deputy Director have been assumed by Bonnie Tavares, who was previously Director of the Division of Community Health Promotion in the Bureau. Rehiring for that position is currently underway. Some realignment of programs has been made within the Bureau: a new Office of Adolescent and Youth Development was created and the Massachusetts Tobacco Control Program was moved out of the Bureau. Additional organizational changes are expected when a current Strategic Planning process is completed.

The Bureau of Family and Community Health is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. The Bureau includes four programmatic divisions:

- **Division for Special Health Needs**
- **Division of Maternal, Child, and Family Health**
- **WIC Program Division (Special Supplemental Nutrition Program for Women, Infants and Children)**
- **Division of Community Health Promotion**

The Bureau also includes the following Offices and support units:

- **Office of Statistics and Evaluation (OSE)**
- **Office of Oral Health**
- **Office of Adolescent and Youth Development**
- **Office of Refugee and Immigrant Health**
- **Administration and Finance Unit**
- **Policy Office**

Finally, the Bureau maintains staff in six regional offices. Many of these staff provide direct services to individuals and families, such as the Health Access Specialists, FOR Families coordinators, and case managers in the Family and Community Support program (CSHCN). Others work closely with BFCH programs, providing regional and local training and technical assistance, coordination, performance monitoring, and other capacity building activities, such as the regional Early Intervention

specialists. Each regional office has a manager, under whose leadership staff work closely with communities to develop a system of care that is responsive to the diverse needs of community members. These staff facilitate the systems building activities in local communities for all Bureau programs and services.

Figure 2 displays BFCH programs and activities schematically in relation to the levels of the “MCH Pyramid.” The pyramid includes the core public health services delivered by MCH agencies hierarchically by levels of service from direct health care services (the tip of the pyramid) to infrastructure building services (the broad base of the pyramid). Figure 2 lists both generic functions and services carried out by MCH agencies that BFCH provides or assures, as well as specific Massachusetts programs and initiatives. Many programs carry out activities at more than one level of the Pyramid (e.g. primary care service providers also assist families with enrollment in WIC or offer other enabling services as well; population-based lead screening programs also provide direct client case management for children found to be lead poisoned). However, for this purpose, each program has been shown only at the level of the Pyramid that represents its primary or dominant focus based on the MCHB definitions for levels of services.

INSERT FIGURE 2 (THE PYRAMID)

1.5.1.2 Program Capacity

MCH-related program areas within the Bureau are listed and briefly described below in Tables 1.5.1.2A, 1.5.1.2B, 1.5.1.2C and 1.5.1.2D, organized by the level(s) of the Pyramid that they primarily address. Organized by Division/Office, these programs are further described in Supplemental Document 5.3.10.

TABLE 1.5.1.2A	
Title V Funded Preventive and Primary Care Services/Programs for Pregnant Women, Mothers and Infants	
Program	Description
Alcohol Screening Assessment in Pregnancy (ASAP) Project	Demonstration project to promote provider screening and appropriate follow-up for alcohol and drug use during routine prenatal care.
Children’s Medical Security Plan	Insurance coverage for preventive and primary care for uninsured children under 19.
Combined Primary Care Programs: Perinatal and Pediatric	Provision of comprehensive primary care to pregnant women and infants in health centers and primary care sites.
FamilyConnection Project	Demonstration project in Family Planning, FIRSTLink, F.O.R. Families, WIC and Early Intervention programs to screen and assist women of reproductive age with issues of alcohol abuse, drug use, smoking and unprotected sex.
FIRSTLink	Newborn screening and community referral system.
Genetics Planning Grant	Planning to ensure access to genetics counseling and services for pregnant women and families of infants with genetic conditions in Massachusetts.
Growth and Nutrition Program	Multidisciplinary services to children with nutritional growth delay (commonly known as Failure to Thrive).
Healthy Start Program	Perinatal insurance coverage, as well as information, referrals, outreach, and health education for uninsured women under 225% of poverty.
Infant Hearing Linkage Project	Outreach to parent and pediatricians to ensure prompt diagnosis and early EI enrollment of children with congenital hearing loss.
Massachusetts Center for Sudden Infant Death Syndrome (SIDS)	Counseling and information to families experiencing sudden infant death from SIDS and other causes; training professionals responding to a family with an infant death; toll-free 24-hour helpline.
MassCARE (Massachusetts Community AIDS Resource Enhancement)	Outreach to pregnant women and obstetrical providers to ensure early identification and enrollment in care of women with HIV, to enhance care for women and prevent HIV transmission from mothers to infants.
MCH Health Education Program	Technical assistance and resource support for MCH health education; development of culturally and linguistically appropriate training, health education strategies and materials.
MCH Home Visiting Programs (FIRSTSteps and Healthy Families)	FIRSTSteps: Home-visiting services for at-risk families with children from pregnancy through age 3. Healthy Families: Home-visiting services from pregnancy through age 3 for first-time parents under 20

TABLE 1.5.1.2A

Title V Funded Preventive and Primary Care Services/Programs for Pregnant Women, Mothers and Infants

Program	Description
MCH Immunization Program	Support to MCH-funded programs to improve infant immunization rates and immunization tracking and information systems.
New England Newborn Screening Program	State mandated program that screens the blood of all newborns for 10 disorders; pilot volunteer program that screens for 19 metabolic disorders, as well as cystic fibrosis. (No MCH Partnership funding)
Perinatal Smoking Initiatives	Efforts integrated into primary and perinatal care services that provide on-site or near-by free or very low cost smoking cessation programs, free materials. Includes an award winning media campaign.
Universal Newborn Hearing Screening	Oversight of mandatory newborn hearing screenings prior to hospital discharge. Promulgation of regulations; approval of hospital screening protocols. (See CSHCN for related follow-up services.)
WIC (Special Supplemental Nutrition Program for Women, Infants and Children)	Nutrition education and counseling, and access to nutritious foods, for low-to-moderate income pregnant and postpartum women, infants and children to age six.

TABLE 1.5.1.2B

Title V Funded Preventive and Primary Care Services/Programs for Children and Adolescents

Program	Description
Abstinence Education Media Campaign	Comprehensive statewide social marketing initiative targeting youth, families and other community members, primarily in Hispanic and Black communities with high adolescent birth rates.
Abstinence-Based Pregnancy Prevention	In-school programs that target middle-school youth in selected communities
Bright Futures Campaign	Public-private partnership to improve the health status of all children by increasing preventive primary care utilization and ensuring age-appropriate content of care for children and adolescents.
Child Health Diary (<i>Growing Up Healthy / Creciendo Sano / Crescer Saudável</i>)	Health, safety, child development and parenting information publication distributed to families of all newborns and others; published in English, Spanish, and Portuguese.
Children's Medical Security Plan	Insurance coverage for preventive and primary care for uninsured children under 19
CLPPP (Childhood Lead Poisoning Prevention Program)	Comprehensive lead poisoning prevention program and enforcement of state lead laws. Services include screening, medical case management, blood lead analysis, environmental case management, education, training, and outreach. (Partial MCH funding but not within the BFCH)
Combined Primary Care Programs: Pediatric and Adolescent	Provision of comprehensive primary care to children and adolescents in health centers and primary care sites.

TABLE 1.5.1.2B
Title V Funded Preventive and Primary Care Services/Programs for Children and Adolescents

Program	Description
Abstinence Education Media Campaign	Comprehensive statewide social marketing initiative targeting youth, families and other community members, primarily in Hispanic and Black communities with high adolescent birth rates.
Enhanced School Health Programs	Funding to school districts to enhance school health service programs and to better meet the specific needs of the given student population.
Family Planning Outreach and Education Initiative (New)	Specialized and enhanced outreach services to hard-to-reach populations, linking them to family planning services in their communities. (Pending final state budget approval)
Family Planning Services	Family planning medical, educational, and outreach services for low-income women, men, and adolescents
FOR Families Program	Hotline and home visiting program for families making the transition from welfare to self-sufficiency.
Injury Prevention and Control Unit	Injury control for children and youth and their families.
Unintentional Childhood Injury Prevention Programs	Resources for local health departments, visiting nurse programs, educators, health care providers and others to integrate childhood injury prevention activities into community-based settings. Includes passenger safety promotion programs and child car seat loan programs.
Emergency Medical Systems for Children	MCHB-funded project to ensure that all children ages 0 -21 have access to high quality pediatric emergency medical services (EMS).
EMSC Partnership Project (new in FY01)	MCHB-funded project for continued support of existing and new initiatives for the enhancement of emergency care for children.
Massachusetts Residential Fire Injury Prevention Project	Demonstration project and evaluation of community-based smoke detector promotion strategies among low-income households with children and elders in three communities
Intentional Injury Prevention	Efforts to raise awareness of the issue of suicide and bring coordination to existing services and programs.
MaxCare	MCHB-funded project to maximize the health and safety of children in out-of-home care
MCH Immunization Program	Support for and promotion of immunization in MCH-funded programs, in collaboration with the Massachusetts Immunization Program.
School-Based Health Centers	Comprehensive primary care centers in high schools, middle schools, and elementary schools.
School Health Services	Ongoing systems development and technical assistance available to all public school systems and private schools. Standard setting, school nurse certification, and continuing education.
The Challenge Fund: Teen Pregnancy Prevention	Continuum of primary prevention services to reduce teen pregnancies in targeted communities with high teen birth rates.
WIC (Special Supplemental Nutrition Program for Women, Infants and Children)	Nutrition education and counseling, and access to nutritious foods, for low-to-moderate income infants and children to age six.

TABLE 1.5.1.2C
Title V Funded Services/Programs for Children with Special Health Care Needs

Program	Description
Early Intervention Services	Comprehensive developmental evaluations, multidisciplinary therapeutic and education services for children ages 0-3 who are at established, biological or environmental risk for development delay. Support and education for parents caring for these children. Pending final state budget approval, EI Respite Services will also be provided.
Early Intervention Services Specialized Training and Support Projects	EI child and family services (see above) for children with low-incidence conditions, including children who are blind and those diagnosed with autism or pervasive developmental disorders.
Family and Community Support Programs	Promote the well being of children with special health care needs and their families. Coordinated by staff located in the central office and in each of 6 regional health offices throughout the state.
Family and Community Support Programs / Case Management Program	Information, referral, and technical assistance to parents and providers; service coordination for families experiencing difficulty in obtaining or maintaining services. Outreach to children who meet the disability criteria for SSI. Service coordination for children eligible for the Kaileigh Mulligan Home Care Program.
Family TIES	Statewide parent-to-parent support and information and referral network for families and providers involved in the care of children with special needs; toll free in-state phone line. Central directory for Early Intervention services; website links parents and providers with up-to-date information.
Growth and Nutrition Program	Services to children with nutritional growth delay (Failure to Thrive).
Mass Initiative for Youth with Disabilities	MCHB-funded "Healthy and Ready to Work" grant to promote the transition to adult autonomy for teens with disabilities.
Massachusetts Genetics Program	Infrastructure support to ensure that Massachusetts consumers have access to a full array of beneficial genetics services without compromising consumer privacy and consumer control of personal genetic information.
MassCARE (Massachusetts Community AIDS Resource Enhancement)	Outreach to pregnant women and obstetrical providers to ensure early identification and enrollment in care of women with HIV, to enhance care for women and prevent HIV transmission from mothers to infants.
MASSTART (Massachusetts Technology Assistance Resource Team)	Specialized nurse consultation to parents and schools to ensure safe placement of technology-assisted and other medically involved children with special health care needs in school settings.
Medical Review Team	Multidisciplinary team that screens all children for whom placement is sought in a pediatric nursing home in Massachusetts fits strict medical and cognitive criteria.

TABLE 1.5.1.2C
Title V Funded Services/Programs for Children with Special Health Care Needs

Program	Description
Parent Initiatives for CSHCN	Variety of parent-driven projects offer multiple and varied opportunities for family members to participate in the development and monitoring of program policies, procedures and practices. Family TIES statewide parent-to-parent support and information and referral network with toll free in-state phone line and website.
Special Medical Fund for CSHCN	Payor of last resort for families with children with special health care needs for services, respite, equipment, medical supplies or other needs related to their child's diagnosis. Payment for special foods and formulas for children and adults with a diagnosis of PKU or other related metabolic disorders.
SSI and Public Benefits Training and Technical Assistance	Information, referrals, and training programs regarding public benefit and health financing programs, eligibility criteria, and application / appeals processes. Statewide toll-free number.
Universal Newborn Hearing Screening and other Hearing Programs for Children	Oversight of mandatory newborn hearing screenings prior to hospital discharge. Promulgation of regulations; approval of hospital screening protocols and of diagnostic audiological centers. Reimbursement of hearing screening and diagnostic hearing evaluations for uninsured or underinsured newborns. Payment for hearing aids based on financial need.

TABLE 1.5.1.2D
Title V Funded Services/Programs for Other MCH Populations or All of Above Groups

Program	Description
Center for Birth Defects Research and Prevention	Population-based statewide surveillance system. Part of 5-year CDC collaborative study of risks, causes, and prevention of birth defects.
Community Health Center Support and Enhancement	State funding for capacity building, infrastructure, and special initiatives to address health disparities; oral health services are a priority.
Folic Acid Campaign	Campaign to increase awareness about adequate folic acid intake, targeting all women to reduce the risk of certain birth defects and the entire population to protect against heart disease and certain cancers.
Food Stamp Outreach	Outreach to families on accessing food stamp benefits.
Genetics Planning Grant	Development of a comprehensive state plan to ensure access to family-centered, comprehensive genetics services for individuals with or at-risk of genetic conditions and their families.
Health Care Access Projects	Outreach to hard-to-reach uninsured children, families, and individuals to enroll them in MassHealth and CMSP
Massachusetts Genetics Program	Infrastructure support to ensure that Massachusetts consumers have access to a full array of beneficial genetics services without compromising consumer privacy and consumer control of personal genetic information.

TABLE 1.5.1.2D
Title V Funded Services/Programs for Other MCH Populations or All of Above Groups

Program	Description
Massachusetts Osteoporosis Awareness Program	Program targets Massachusetts residents and health professionals to promote prevention of osteoporosis through good nutrition, exercise, and injury prevention.
Office on Health and Disability	Access to reproductive and preventive services for women with disabilities, including access to violence and sexual assault prevention and service programs.
Office of Oral Health	Enhancement of oral health in Massachusetts through the development and support of organized systems of dental disease prevention, treatment, research, and education.
Office of Statistics and Evaluation	Computer Systems and Technical Support; Program Support; Data Analysis, Research and Evaluation
Other Healthy Nutrition and Physical Activity Programs	Other healthy nutrition and physical activity initiatives include broad-based community involvement to promote healthy eating habits, regular physical activity, and reduce health risks factors. (See also Mass. Osteoporosis Awareness and Folic Acid Campaign)
Primary Care Systems Support	Programs and activities designed to promote the availability of affordable, primary health care. Initiatives include the Office of Rural Health, Primary Care Cooperative Agreement, and State Loan Repayment Program.
Regional Center for Poison Control and Prevention – serving Massachusetts and Rhode Island	A 24-hour hotline providing information on poisoning emergencies and prevention. Now serving both Massachusetts and Rhode Island through a jointly funded single program.
State Systems Development Initiative Grant (SSDI)	Support and enhancement for state MCH needs assessment and performance monitoring efforts.
Violence Prevention and Intervention Services	Continuum of education, outreach, prevention, intervention, and data/surveillance programs targeting the reduction and prevention of sexual assault, domestic violence, and related threats to the safety of women, children and families.
Sexual Assault Prevention and Survivor Services	Community and professional education on sexual assault prevention and intervention; free direct services to survivors through Rape Crisis Centers
WATCH (Women Abuse Tracking in Clinics and Hospitals) Project	Development of screening, documentation, and assessment protocols regarding intimate partner violence for hospital emergency departments; training of medical providers.(ending during FY01)
SANE (Sexual Assault Nurse Examiner) Program	Specialized training and certification of SANEs; forensic evidence collection and medical care for sexual assault patients in hospital ERs; collaboration with rape crisis centers, police, district attorneys.
Rural Domestic Violence and Child Victimization Program	Direct services to children who witness domestic violence and their mothers. Community education and outreach; provider education.
Massachusetts Violence Prevention Task Force	Support of community coalitions to plan, develop and implement violence prevention initiatives; violence prevention workshops; annual conference.

TABLE 1.5.1.2D
Title V Funded Services/Programs for Other MCH Populations or All of Above Groups

Program	Description
Immigrant and Refugee Domestic Violence and Sexual Assault Prevention Programs	Violence against women prevention and intervention programming in specific immigrant and refugee newcomer communities across the state.
Batterers Intervention Programs	Certification of programs for adolescent and adult batterers to promote cessation of dating and domestic violence, batterer accountability, and victim safety.

1.5.1.3 Other Capacity

Approximately 370 persons employed through the Department work on Title V programs; of these 234 are paid from Title V Partnership funds and the rest are paid from MCH-related accounts. Approximately 120 of the total are usually based in the six regional offices; the others work out of our central office in downtown Boston. Brief biographical sketches of the Title V senior management team are included in Supplemental Document 5.3.2. A biography is not available for one senior management position currently vacant: Director of the Division of Community Health Promotion.

Not counting short-term positions and service on task forces, the Bureau employs 16 parents who represent approximately 8 full-time equivalent staff. Flexibility in both work hours and locations have enabled us to hire and retain this large group of committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs. More information on our extensive parent involvement initiatives is provided in Sections 2.4.3.2. (FY99) and 4.1.3.2. (FY01). Staff and parents working on Title V programs are listed in Table 1.5.1.3. This table includes all MCH-related staff and consultants. Senior Managers and Unit Directors are listed individually; others are grouped into general job function types by MCH population groups. Numbers of full-time equivalents and vacancies should be regarded as point estimates only. Data capacity is addressed further at Core Health Status Indicator #5 and in Supplemental Document 5.3.10 in the section that describes the Office of Statistics and Evaluation.

**TABLE 1.5.1.3
State Title V Key Staff and Parents**

Codes:

P = Paid, C = Contract, V = Voluntary

Senior Level Management and Bureau-wide Support Services				
Position Title/Category	Program * = Senior Position, Biography Attached	FTEs	P, C, or V	Vacant #FTEs
Sally Fogerty, Assistant Commissioner * Title V Director	Director, Bureau of Family and Community Health (BFCH)	1.0	P	
Deborah Allen, Division Director, BFCH *	Division for Special Health Care Needs (includes CSHCN Programs)	1.0	P	
Lisa Levine, Division Director, BFCH *	Division for Maternal, Child, and Family Health (includes many MCH programs)	1.0	P	
TBD, Division Director, BFCH * (no Bio – vacant)	Division of Community Health Promotion (includes a number of MCH and population-based prevention programs)	1.0	P	1.0
Mary Kelligrew Kassler, Division Director, BFCH State WIC Director * (not in Partnership budget-no bio)	WIC Program Division	1.0	P	
Marlene Anderka, Office Director, BFCH *	Office of Statistics and Evaluation (information technology and data support and analysis services for BFCH)	1.0	P	
Julia Burns, Office Director, BFCH *	Office for Administration and Finance (administrative support and fiscal oversight for BFCH)	1.0	P	
Regional Office Managers (one in each of six DPH regional offices)	Bureau of Family and Community Health	6.0	P	
Other Bureau-wide staff (policy and planning, administration and finance, support staff) funded through MCH Partnership and related programs	Bureau of Family and Community Health	27.5 1	P C	1.0

Parents				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTEs
TBD, Director of Parent Initiatives	Division for Special Health Needs (DSHN)	1.0	P	1.0
Polly Sherman, Statewide Family Network Director	Parent Initiatives, DSHN	1.0	C	
Joanne Spencer, Coordinator of Family Support (new position)	Parent Initiatives, DSHN	.75	C	
Regional Parent Coordinators (six half-time individuals, one in each DPH regional office)	Family TIES, DSHN	3.0	C	

Parents				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTEs
Darla Gundler, Statewide Director, Parent Leadership Project	Early Intervention, DSHN	1.0	P	
Beth Dworetzky, co-Statewide Director, Parent Leadership Project	Early Intervention, DSHN	?	C	
Parent Leadership Regional Coordinators (6 individuals, one in each DPH regional office; .125 FTE (20 hours/month) each)	Early Intervention, DSHN	.75	C	.125
Parent members of Early Intervention Interagency Coordinating Council (ICC)	Early Intervention, DSHN	Variable	V	
Other parent consultants, specific projects	MASSTART, Infant Hearing Linkage, etc.; DSHN	Variable	C	

Programs/Services for Pregnant Women, Mothers, and Infants				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTEs
Donna Johnson, Unit Director (see Children below also), Division of Maternal, Child and Family Health (DMCFH)	MCH Family Support and Education Services (MCH Home Visiting, Max Care, etc.),	.4	P	
Maureen McHugh, Unit Director (see Children below also), DMCFH	Health Access Unit (Healthy Start, CMSP, Health Access Line)	.5	P	
Vacant, Unit Director (see Children below also), DMCFH	Primary Care Unit (MCH Primary Care, Family Planning, CHC Support)	.5	P	.5
Sally Graham, Program Director (see Children below also)	FOR Families Program	.5	C	
Program Managers, Contract Monitors, Systems support, DMCFH	All DMCFH programs	11.0 7.0	P C	2.0
Health Access Intake Staff and Regional Coordinators	Healthy Start, CMSP	16.0	P	
Regional Coordinators, Home Visitors, Resource Specialists	FOR Families Program	14.5	C	.5
Other Support Staff:	All programs	5.0 1.0	P C	1
Clinical program oversight staff & consultants (nursing , dental, social work, and various therapy professionals)	Primary Care, Family Planning, etc.	1 1	P C	

Programs/ Services for Children and Adolescents				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTEs
Donna Johnson, Unit Director (see Women and Infants also), Division of Maternal, Child and Family Health (DMCFH)	MCH Family Support and Education Services (MCH Home Visiting, Max Care, etc.),	.4	P	
Maureen McHugh, Unit Director (see Women and Infants also), DMCFH	Health Access Unit (Healthy Start, CMSP, Health Access Line)	.5	P	
Vacant, Unit Director (see Women and Infants also), DMCFH	Primary Care Unit (MCH Primary Care, Family Planning, CHC Support)	.5	P	.5
Vacant, Unit Director, DMCFH	School Health Unit (including School-Based Health Centers, School Health Services, and Enhanced School Health Services)	1.0		
Sally Graham, Program Director (see Women and Infants also), DMCFH	FOR Families Program	.5	C	
Dianne Hagan, Director	Office of Adolescent and Youth Development	1.0	P	
Michael Monopoli, DMD., Director	Office of Oral Health	.5	P	
Cindy Rodgers, Co-Unit Director, Division of Community Health Promotion (DCHP)	Injury Control and Prevention Unit	.5		
Carlene Pavlos, Co-Unit Director, DCHP	Injury Control and Prevention Unit	1.0		
Program Managers, Contract Monitors, Project directors, other program staff, DMCFH, DCHP, OAYD, Oral Health, Lead Poisoning	All related DMCFH, DCHP, OAYD, oral health, lead poisoning programs	9.5 21.75	P C	1 11 (most new)
Health Access Intake Staff and Regional Coordinators (see Women and Infants also)	Healthy Start, CMSP	16	P	
Regional Coordinators, Home Visitors, Resource Specialists	FOR Families Program	14.5	C	.5
Other Support Staff	All related programs	8.5 1.0	P C	2
Clinical program oversight and assistance staff and consultants (nursing , dental, social work, and various therapy professionals)	Primary Care, Family Planning, School Health, etc.	1 8	P C	8 (new)

Programs/Services for Children with Special Health Care Needs				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTEs
Ron Benham, Director	Early Intervention Services, Division for Special Health Needs (DSHN)	1.0	P	

Programs/Services for Children with Special Health Care Needs				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTEs
Whitney Garberson, Director	Family and Community Support, DSHN	1.0	P	
Vacant, Director of Parent Initiatives – see Parents section	DSHN			
Cheryl Bushnell, Director	Office for Health and Disability, DSHN	1.0	P	
Program Managers, Contract Monitors, Project directors, other program staff	All DSHN programs (Infant Hearing, MassCARE, Special Medical Fund, MIYD, etc.)	14.35 4.5	P C	3 1
Case Management/Family Support staff and Regional Coordinators	Family and Community Support, DSHN	19.7	P	
Other Support Staff	All programs	5	P	
Clinical program oversight and assistance staff (MD, RNs, therapists)	All programs	1.35 .25	P C	
See also numerous parent positions above				

Planning, Evaluation and Data Analysis				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTEs
Nancy Wilber, Project Manager, OSE	Special Health Care Needs	1.0	P	
Dale McManis, Project Manager, OSE	School and Adolescent	1.0	P	
Elizabeth Barden, Project Manager, OSE	Nutrition and Primary Care	1.0	P	
Carter Pratt, Project Manager, OSE	Injury and Violence Control	1.0	P	
Vacant, Project Manager, OSE	Perinatal Health	1.0	P	1.0
Vacant, Deputy Director, OSE	Systems and Operations	1.0	P	1.0
Lisa Schalick, Director	Birth Defects Research & Prevention	1.0	P	
Systems Analysts, Programmers, other research and analytic staff	All MCH-related programs	21.5 23.5	P c	2 3.5
Technical support and MassCHIP	All programs	6	P	2
Other support staff	All programs	2 2	P C	

1.5.2 State Agency Coordination

The BFCH views both intra-agency and interagency coordination as being essential to the achievement of its mission on behalf of improved maternal and child health. The Bureau maintains and promotes extensive networking and systems development relationships at the national, state, and local levels. These relationships include provider, non-profit, and other organizations; advocacy groups; coalitions, task forces, and community groups; other state agencies and governmental groups; universities and colleges; and internal MDPH working groups. We have summarized these relationships in the master listing below, categorizing them by type of agency/organization. Many of the activities carried out through these relationships are noted throughout the Annual Report and Annual Plan sections of this document as they related to specific performance measures or Title V priorities.

Table 1.5.2

Key State Title V Relationships

Other State Human Services Agencies and Committees / Cabinets
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MEDICAID (MassHealth) AGENCY = Massachusetts Division of Medical Assistance (DMA)

Joint workplan developed to assure quality Medicaid services to MCH populations, with the following areas of focus:

- EPSDT
- Follow-up outreach and service referrals
- Behavioral health services
- School-Based Health Centers (SBHCs); Enhanced School Health Services
- Medicaid and Children with Special Health Care Needs
- Early Intervention Federal Financial Participation (FFP) project (payments for developmental educators)
- Perinatal health quality improvement project (increasing adequacy of care)
- Preventive pediatric and adolescent health care quality improvement project (using *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*)
- Oral health and dental care access models
- Medicaid Perinatal, Child and Adolescent Advisory Group
- Medicaid HMO and PCC work groups
- Healthy Start/CMSP ISA
- *FIRSTSteps* ISA
- Title XXI, CHIP, Section 1115(b) waiver
- Kaileigh Mulligan Home Care for Disabled Children Program
- Medical Review Team; subcommittee work group on short-term stay nursing home policy
- Issues related to children and youth in foster care
- Massachusetts WIC Program /Medicaid Letter of Agreement and referrals
- Joint participation in Early Intervention Fiscal Work Group, aimed at restructuring EI payment system to promote service delivery in natural environments

Other Medicaid Issues and Activities:

- Increasing data sharing
- Joint Outreach mini-grants programs

Joint DMA/MCH Immunization Program initiatives
Maternal AIDS Working Group
MPDH/DMA workgroup meetings on FFP for perinatal outreach services
Reimbursement for nutrition services
Reimbursement rates for family planning services
Family planning outreach to Medicaid clients (“Keep Teens Healthy” Program)
DMA/DMH/DSS Child Blended Funding Robert Wood Johnson Initiative (on Steering Committee)
Enrollment outreach and assistance for families transitioning off TANF
Enrollment outreach to child care providers and families using child care

Department Of Education/Local Educational Authorities

Joint DOE/DPH planning committee
Joint work with DOE and DMA for expanded school health and health education program
Development of comprehensive school health programs
DOE Health and Human Services Advisory Council
Massachusetts Family Literacy Consortium
Statewide Advisory Commission for Special Education (SAC)
Early Childhood Advisory Council
Community Partnerships for Children
Preschool and School Age Child Care Standards
DOE Family Network Initiative
School Linked Services (SLS) Projects (previously under Executive Office of Education)
Technical Assistance/Training Collaborative
Bureau of School Nutrition Services collaboration
Massachusetts School Nutrition Task Force
SABES (System for Adult Basic Education Support)
Teen Dating Violence Initiative: prevention and intervention program
Safe and Drug Free Schools

Executive Office of Health and Human Services (EOHHS)

Children's Policy Group (also known as the Children's Integrated Services Group)
[representatives from all EOHHS departments and agencies who provide services to children and youth -- has focused on the development of an integrated, coordinated approach for providing health and human services for children within the state system of care, including the prevention of and appropriate funding for out-of-home placements for children in need.]
Adolescent Health Council
Youth Development Advisory Group
Targeted Cities Initiative

Community Coalitions coordination (see below under Support for Communities)

MassCALL (Massachusetts Collaborative for Active Leadership and Learning)
Community Health Centers Work Group (DMA, MDPH, Division of Health Care Financing and Policy); convened by MDPH
Early Care and Education Recruitment and Retention
Infant-Toddler Services Summit

Department of Transitional Assistance (DTA)

FOR Families
ISA to MDPH for Resource Line and Home Visiting and Referral Services for Families being transitioned off “welfare.”

Collaborative monitoring of the impact of Welfare Reform
Family Planning health education materials translated for recipients
Policies and programs for homeless/emergency shelter programs, pregnant teens
Food Stamp Outreach

Division of Health Care Finance and Policy

Free Care Pool policies
Establishment of rates
Assessments of insurance status
Linkages to hospital data for IQ projects

Division of Insurance

Managed Care Ombudsman Line
Membership on MDPH Universal Newborn Hearing Screening Advisory Committee)

Department of Social Services (DSS)

Joint DSS/Children's Trust Fund (CTF)/DPH liaison work on Healthy Families/DSS interface
Children's Justice Act Advisory Committee
DSS AIDS Review Teams (regionally based)
Foster Care Advisory Committee
Advisory Committee for Special Kids: Special Care (their special needs MCO plan)
Domestic Violence Unit
Liaison work on domestic violence issues and policies, and on standards for court-based child care

Department of Youth Services

Office of Child Care Services (OCCS) (formerly the Office for Children)

Child Care Advisory Group

Department of Revenue Child Support Program

Department of Environmental Protection (joint coordinating council to improve local health efforts)

Regional Interagency Teams

Massachusetts Rehabilitation Commission

Disability Determination Services (DDS) Advisory Committee
SSI/Disabled Children's Program
Statewide Head Injury Program
Vocational and Independent Living
Home Modification for Disabled Loan Program Advisory Group – new joint project of MRC and CEDAC – Community Economic Development Assistance Corp.

Massachusetts Partnership for Transition (MPT)

Statewide coordinating council aimed at supporting the transition of youth with disabilities to adulthood and adult service systems; representatives of the Department of Education, Massachusetts Rehabilitation Commission, Department of Mental Retardation, Department of Employment and Training, Federation for Children with Special Needs, Children's Hospital, Institute for Community Inclusion (an MCHB-University-Affiliated Program or UAP) at Children's Hospital and UMass/Boston, and a number of other agencies and organizations.

Commission for the Blind

Commission for the Deaf and Hard of Hearing

Membership on MDPH Universal Newborn Hearing Screening Advisory Committee)

Department of Mental Health

Assessments of current pediatric mental health services
Annie B. Casey grant - Roxbury Unites for Families and Children
Child Care and Mental Health State Team

Department of Mental Retardation

Families Organizing for Change – Family Support
Acquired Brain Injury Committee

Children's Trust Fund Advisory Board, and other work groups focusing on universal home visiting

Governor's Commission on Responsible Fatherhood and Family Support

Governor's Commission on Gay and Lesbian Youth

County District Attorneys Offices

Executive Office of Public Safety

Massachusetts State Police
Office of the Chief Medical Examiner
Massachusetts Governor's Highway Safety Bureau
VAWA Programs Division
Department of Fire Services

Massachusetts Highway Department

Massachusetts Rural Development Council

Group Insurance Commission

Disabled Persons Protection Commission

Massachusetts Office of Victim Assistance

Massachusetts Violence Prevention Task Force (hosted by MDPH)

Governor's Commission on Domestic Violence

Transition, Immigrant and Refugee, Research and Evaluation, and Community Education
Subcommittees

Health Care and Batter Intervention Working Groups

Legislative Oral Health Commission (Advisory Committee and staff support)

Massachusetts Office of Refugees and Immigrants (MORI)

Health Departments of New York, Connecticut, Rhode Island, and Maine on folic acid awareness activities

Other Department of Public Health Bureaus and Programs

Bureau of Health Statistics, Research and Evaluation

BRFSS

MassCHIP

Vital Statistics

EDSCIP

Communicable Disease Control

Massachusetts Immunization Program (MIP)

Tuberculosis Control

Hepatitis C Advisory Group

Sexually Transmitted Disease Prevention

Women's Advisory Committee

Bureau of Substance Abuse (BSAS)

ASAP grant

Interagency Working Committee on Perinatal Substance Abuse

Interagency Working Committee on Youth Substance Abuse

AIDS/HIV Bureau

MDPH AIDS Management Group

Bureau of Environmental Health Assessment

Joint concerns related to schools, childhood asthma, childhood lead poisoning, childhood cancer, etc.

Youth Services Committee (previously Adolescent Services Committee)

Bureau of Health Quality Management (BHQM)

Childhood Lead Poisoning Prevention Program
 Office of Emergency Medical Services
 Perinatal Advisory Committee
 Facility Licensure and Certification Division
 Food and Drugs
 Corrections Committee
 Maternal Morbidity and Mortality Review Team (with BHQM)
 MDPH Injury Prevention Working Group
 MDPH Community Health Worker Task Force
 CommonGround (department-wide initiative working with community-based agencies experiencing difficulties).
 Office of Minority Health
 Office of Healthy Communities
 27 Community Health Network Areas (CHNAs)

- Approximately two-third's of the CHNAs are addressing some MCH-related issue as their primary target or one of their priorities (e.g., adequacy of prenatal care, childhood asthma, childhood immunizations, breastfeeding, teen substance abuse, teen pregnancy, and violence prevention).
- BFCH staff are team leaders or members of each CHNA.

 Regional Prevention Centers
 Prevention Centers Joint Bureau Management Team
 MCH health education support
 MCH Immunization Program joint site visits and in-service programs
 Support for training youth specialists across programs and across prevention topics (tobacco, substance abuse, teen pregnancy prevention, violence prevention, HIV/AIDS, etc.)
 Non-categorical support for local coalitions and partnerships
 Community Health Education Training – through a variety of venues such as CHEC, MDPH Prevention Centers, etc.
 Statewide Community Health Worker Network
 An **Interagency Technical Assistance (TA) Team** of state program managers (EOHHS, MDPH, DOE, EOE, DSS, and the Children's Trust Fund) continues its work to enhance coordination of technical assistance and training systems to support the large number of state-funded community-based coalitions and partnerships that are addressing healthy communities, families, and children.

Local and Federally Funded Agencies and Health Centers

Relationships with all federally approved and other licensed Community Health Centers
 Relationships with all Title X and other licensed Family Planning agencies
 Massachusetts League of Community Health Centers
 National Highway Traffic Safety Administration
 U.S. Consumer Product Safety Commission
 Federal Department of Health and Human Services Region I

- Title X (Family Planning) regional office
- Federal Region I Women's Health Working Group
- New England Nutritionists (Region I) for MCH & Special Health Care Needs
- Public Health Managed Care Initiative (asthma, diabetes, tobacco, and adult immunization work groups)

 Federal Administration for Children and Families

- Regional Child Care Bureau
- Head Start Bureau

Head Start Programs
Early Head Start Programs
Head Start Collaboration Council
Federal Department of Agriculture; Northeast Regional Office
Federally-funded Boston Healthy Start Initiative (BHSI)
Local Health Coordinating Council (MDPH and DEP)
Relationships with all local and regional school districts and with local health departments

Associations, Organizations, and non-governmental Task Forces/Committees

American Academy of Pediatrics – Massachusetts Chapter (MAAP)
MAAP-HMO Working Group
Massachusetts Hospital Association
Massachusetts Medical Society
Joint survey of physicians concerning ability to manage care of adults with pediatric-onset conditions
Massachusetts Chapter, ACOG
Mass Chapters of Family Practice, Nurse Midwifery, Emergency Room Physicians, and other professional organizations
Massachusetts Dental Association
Massachusetts Nurses Association
Massachusetts Primary Care Association
New England SERVE
Massachusetts Consortium for Children with Special Health Care Needs - a consortium of state agencies, providers, and advocates, convened by New England SERVE, aimed at enhancing services for CSHCN in managed care (including developing a definition of CSHCN). Members include representatives from MDPH, DMA, DSS, Federation for Children with Special Needs and Family Voices, Children’s Hospital, Massachusetts General Hospital, a managed care organization, and others
Neighborhood Health Plan CSHCN Project
Massachusetts Developmental Disabilities Council (MDDC)
Massachusetts Nutrition Board
5-A-Day Statewide Coalition
Nurse Midwifery Work Group
Boston Maternal and Infant Health Work Group
Springfield Maternal and Child Health Commission
Worcester Infant Mortality Reduction Committee
Multiple coalitions, task forces, and networking committees with other state agencies in specific regions of the Commonwealth
Healthy Families Massachusetts Coalition (on Steering Committee)
United Way Success by Six Campaign - Leadership Council
Institute for Health and Recovery
Healthy Communities Advisory Board
Massachusetts Early Intervention Consortium
Massachusetts School Physicians’ Committee
John Snow, Inc. – coordination of family planning training initiatives and representation on Regional Advisory Committee
Family Planning Association
Educational Development Corporation (EDC) – collaboration on CDC VOICES project to improve HIV education and prevention messages in family planning, STD, and HIV community sites

Massachusetts Public Health Association
 ASTDHPPHE (Association of State and Territorial Directors of Health Promotion and Public Health Education)
 ASTPHND (Association of State and Territorial Public Health Nutrition Directors)
 National Association of Family Planning Directors
 National Association of WIC Directors
 National Healthy Mothers, Healthy Babies Coalition
 Healthy Mothers, Healthy Babies Coalition of Massachusetts
 March of Dimes – Massachusetts Chapter
 Women’s Tobacco Task Force (a statewide, interagency to assist providers of tobacco services targeting women and girls share resources, network and give input to policy).
Massachusetts Health Quality Partnership (MHQP). This partnership, which includes MHA, MCOs, and others, is working to improve hospital-based and physician group services and Quality Improvement efforts
Massachusetts Health Assessment Partnership. This partnership is working to improve data sharing for quality improvement; members all HMOs/MCOs, MassHealth (DMA), Massachusetts Hospital Association, and MHQP (see above).
 Maternity Initiative Work Group
 Blue Cross/Blue Shield Obstetrical Collaborative
 Massachusetts Coalition of School-Based Health Centers
 Coalition Organized for Health Education in Schools (COHES)
 Children’s Safety Network
 Safe Kids Coalitions in Boston and Western Mass.
 National Fire Protection Association
 Northeast Injury Prevention Network
 Massachusetts Alliance of Samaritans Services – and 5 individual Samaritans chapters
 Violence Prevention Networking Group
 Jane Doe, Inc.: The Massachusetts Coalition Against Sexual Assault and Domestic Violence
 Statewide Sexual Assault Prevention and Intervention Network (SSAPIN)
 Massachusetts Association for the Treatment of Sexual Abusers
 Massachusetts District Attorneys’ Association

Tertiary Care Facilities and Universities
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Massachusetts University Affiliated Programs (UAPs) - E.K. Shriver Center and Children's Hospital Medical Center
 Children’s Hospital Medical Center
 Advisory Committee to Children’s Hospital Pediatric Alliance for Coordinated Care (chaired by DSHN Director)
 Baystate Medical Center
 UMass Memorial Medical Center
 Massachusetts General Hospital
 Brigham and Women's Hospital
 Boston Medical Center
 Beth Israel Deaconess Medical Center
 New England Medical Center
 St. Elizabeth's Medical Center
 Harvard School of Public Health
 Boston University School of Public Health
 University of Massachusetts – Boston

University of Massachusetts – Amherst
Tufts University
Tufts University School of Medicine
Brandeis University
Simmons College

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See the **FY99 Expended** columns in **ERP Form 3 (State MCH Funding Profile)**, **ERP Form 4 (Budget Details by Types of Individuals Served)**, and **ERP Form 5 (State Title V Programs Budget and Expenditures by Types of Services)**. The **Endnotes** for the Forms provide extensive additional details and explanations about the amounts shown, including differences between budgeted and expended amounts, changes in the levels of funding categories across years, and the sources of state Partnership funds and other Federal funds. (These documents are found in Supporting Documents Section 5.8.)

The FY99 Unobligated Balance expended is substantially higher than the amount originally budgeted. We generally do not fully budget the sum of the new allocations and the carryover from the previous year; therefore the sum of lines 1 and 2 in any Budgeted Column is not the same as "Total Funds Available." The precise amount of carryover cannot be calculated at the time the new budget is prepared, as accounts payable extends for at least 3 months after the close of the state fiscal year.

The other systematic difference between the Federal Budgeted and Expended Columns is that when showing the budget, the new federal award is shown in full (per instructions) and only the amount of unobligated carry-forward funds necessary to meet our program needs is budgeted. However, expenditures are always paid first with the "oldest" federal funds, not the new award. Therefore for expenditures, only the amount of the new grant needed to make all budgeted payments is actually expended. The final federal balance forward for FY99 was \$2,925,998, whereas only \$1,433,415 had been budgeted originally.

In FY99 there appears to be a substantial federal under-expenditure compared with the FY99 projected budget (a total of \$11,440,945 expended compared with \$13,640,822 budgeted). While some underspending was expected, the continued size of the discrepancy was unexpected. It appears due to a continued unusually high number of staffing vacancies for most of the year, including a number of management positions, systems analysts, and senior data managers. In addition, a sizeable federal reserve was budgeted for State FY00 in order to cover the costs of developing comprehensive client data, billing, and vendor accountability computer system for early intervention services, home visiting, and other service types.

2.2 Annual Number of Individuals Served

See **ERP Form 6** (*Number and Percentage of Newborns and Others Screened Confirmed and Treated*); **Form 7** (*Numbers of Individuals Served (Unduplicated) Under Title V*); **ERP Form 8** (*Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX*); and **ERP Form 9** (*MCH Toll-free Telephone Line Data Form*). The **Endnotes** for each of the Forms provide additional details and explanations about the data shown. (These documents are found in Section 5.8.)

In relation to Form 7, Massachusetts is continuing to report information about these same individuals by their race/ethnicity as well as their insurance status. This Supporting table, “*Number of Individuals Served (Unduplicated) Under Title V, FY99, by Race/Ethnicity*,” may be found as Supporting Document 5.3.4 in Section 5.3.

Further information on the number of persons directly served by each service program type -- by general federal category (pregnant women, infants, other children, and children with special health care needs) --is provided in the table, “*Program Service Numbers by MCH Categories, FY99*” included as Supporting Document 5.3.3 in Section 5.3. The table also shows the numbers of persons reached through indirect services and public education, as well as individuals served who are not included in the Title V categories; these counts are not included in ERP Form 7.

In relation to ERP Form 9, Massachusetts is reporting on two toll-free phone lines. The Bureau also maintains a third line for more specific information and technical assistance on SSI and related public benefits for families with children with special health care needs. It is described and its utilization in FY99 documented in the Endnotes for Form 9. Additional narrative information about the toll-free lines may be found in Section 4.2, “*Other Program Activities*.”

2.3 State Summary Profile

See **ERP Form 10**. The Profile is also included in Supporting Document Section 5.8.

2.4 Progress on Annual Performance Measures

See **ERP Form 11** for documentation on the status of each performance indicator. The **Endnotes** to Form 11 provide additional information and explanations about the annual performance indicators and rates shown.

See Table 2.4 below for an overview of all Title V Programs and Activities Areas by Level of the Pyramid for each MCH Population. The specific activities in FY99 that contributed to the performance measure achievements are summarized in the following section after Table 2.4, for each National and

State Negotiated Performance Measure, Outcome Measures, and selected State Priority areas. Many program activities and MCH initiatives address a number of the measures, outcomes, and priorities. We have attempted to indicate these with cross-references in the text of the annual report. In general, information is presented only once, for the most relevant Measure. A few other significant program activities, not related to measures, outcomes, or priorities, are presented at the end of the section.

In this section, the level(s) of the pyramid indicated for a particular program or activity reflect those components of the program that addressed and/or contributed to the particular measure; this may or may not be the dominant pyramid level for that program as displayed visually in Figure 2.

During FY99 the Bureau produced a number of MCH-related reports, informational materials, analytic studies, brochures, and other materials for public distribution. It also issued MCH-related Requests for Responses (RFRs), and submitted a number of MCH-related grant applications. See the Supporting Document in Section 5.3.5 for a descriptive listing.

Status of Progress on Measures for FY99 Annual Report

Overall, Massachusetts met or exceeded its Annual Performance Objectives for 13 of 18 Core Performance Measures, 4 of 10 State Negotiated Measures, and 5 of 6 Outcome Measures for FY99 (or the most recent data reporting period). [Note: two Negotiated Measures were eliminated as part of the Needs Assessment process and are not counted as being either met or not met.] For five Core Performance Measures (# 05, 14, 16, 17, and 18) and four Negotiated Measures (# 02, 04, 07, and 09), the Commonwealth did not achieve the rates we had projected. A brief discussion of the differences and reasons for not meeting our targets is included in a narrative with each of these measures below; see the Endnotes to Form 11 also.

CODES FOR LEVELS OF PYRAMID:

- D = Direct Health Care Activities
- P = Population-Based Activities
- E = Enabling Activities
- I = Infrastructure/ Capacity Building Activities

CODES FOR INDICATORS:

4 = some program services in this area

TABLE 2.4

Title V Activities by Level of the Pyramid for MCH Populations

(See Tables 1.5.1.2A-D and Supporting Document 5.3.10 for more information on each program;

see Annual Report and Annual Plan sections for detail on specific activities for each population group and pyramid level)

MCH Population Group:	Pregnant Women, Mothers and Infants				Children and Youth				CSHCN				Other Groups; Multiple MCH Groups				
	D	E	P	I	D	E	P	I	D	E	P	I	D	E	P	I	
Abstinence Education Media Campaign								4									
Abstinence-Based Pregnancy Prevention Education								4									
Alcohol Screening Assessment in Pregnancy (ASAP) Project			4	4													
Birth Defects Surveillance Project (CDC Centers for Excellence Grant)			4	4								4			4	4	
Bright Futures Campaign			4	4			4	4			4	4					
Child Health Diary			4	4			4	4			4	4					
Children's Medical Security Plan		4				4											
CLPPP (Childhood Lead Poisoning Prevention Program)					4	4	4	4		4		4			4	4	
Combined Primary Care Programs: Pediatric, and Adolescent	4	4		4	4	4		4	4	4		4					
Combined Primary Care Programs: Perinatal	4	4		4													
Early Intervention									4	4		4					
Emergency Medical Systems for Children								4				4					
EMSC Partnership Grant (new in FY01)								4				4					
Enhanced School Health Services						4	4	4		4	4	4					
Family Planning Services					4	4		4					4	4			4
Family Planning Outreach and Education (new in FY01)						4	4	4						4	4	4	4
FIRSTLink Initiative		4	4	4						4	4	4					
Folic Acid Campaign				4				4				4					4
Food Stamp Outreach																	4
FOR Families Program						4								4			

MCH Population Group: Level of Pyramid:	Pregnant Women, Mothers and Infants				Children and Youth				CSHCN				Other Groups; Multiple MCH Groups			
	D	E	P	I	D	E	P	I	D	E	P	I	D	E	P	I
Genetics Planning Grant				4								4				4
Growth and Nutrition Program									4	4						
Health Care Access Projects						4								4		
Healthy Start Program		4	4													
Infant Hearing Linkage Project				4									4			
Injury Prevention and Control Unit				4				4					4			4
Intentional Injury Prevention								4								4
Massachusetts Residential Fire Injury Prevention Project								4								4
Passenger Safety Programs				4				4					4			4
Unintentional Childhood Injury Prevention Programs								4								4
Mass Initiative for Youth with Disabilities										4			4			
Massachusetts Center for Sudden Infant Death Syndrome (SIDS)		4		4						4			4			
Massachusetts FamilyConnection Project (new in FY01)		4		4												
Massachusetts Genetics Program				4									4			4
Massachusetts Osteoporosis Awareness Program																4
MassCARE (Massachusetts Community AIDS Resource Enhancement)		4		4						4			4			
MASSTART (Massachusetts Technology Assistance Resource Team)													4			
Max Care			4	4			4	4			4	4				
MCH Health Education Program				4				4								
MCH Home Visiting Programs (FIRSTSteps and Healthy Families)	4	4		4	4	4		4		4						
MCH Immunization Program			4	4			4	4								
Medical Review Team													4			
New England Regional Newborn Screening Program			4								4	4				
Office of Oral Health					4		4	4						4		4
Office of Statistics and Evaluation				4				4				4				4
Other Healthy Nutrition and Physical Activity Programs																4

MCH Population Group: Level of Pyramid:	Pregnant Women, Mothers and Infants				Children and Youth				CSHCN				Other Groups; Multiple MCH Groups				
	D	E	P	I	D	E	P	I	D	E	P	I	D	E	P	I	
Parent Initiatives for CSHCN										4			4				
Perinatal Smoking Initiatives			4	4													
Primary Care Systems Support (Primary Care Cooperative Agreement, State Loan Repayment Program, Office of Rural Health)																	4
Regional Center for Poison Control and Prevention – serving Massachusetts and Rhode Island			4	4			4	4			4	4			4	4	
School Health Services								4					4				
School-Based Health Centers					4	4	4	4	4	4	4	4	4				
SHCN Family and Community Support Programs / Case Management Program										4			4				
Special Medical Fund for CSHCN										4							
SSI and Public Benefits Training and Technical Assistance													4				4
State Systems Development Initiative Grant																	4
The Challenge Fund: Teen Pregnancy Prevention					4	4		4									
Universal Newborn Hearing Screening and other Hearing Programs for Children			4	4					4	4			4				4
Violence Prevention and Intervention Services													4	4	4	4	
Sexual Assault Prevention and Survivor Services															4	4	
WATCH (Women Abuse Tracking in Clinics and Hospitals) Project																	4
SANE (Sexual Assault Nurse Examiner) Program													4		4	4	
Rural Domestic Violence and Child Victimization Program																	4
Massachusetts Violence Prevention Task Force																	4
Immigrant and Refugee Domestic Violence and Sexual Assault Prevention Programs																	4
Batterers Intervention Programs														4			4
WIC (Special Supplemental Nutrition Program for Women, Infants and Children)		4	4	4		4	4	4		4	4	4					

TABLE NPM-1B

Programs/Activities Needing Review/Revision for NPM #1

Programs/Activities	Pyramid
Family and Community Support (case management) <ul style="list-style-type: none"> We have struggled to modify the model to serve greater numbers by 1) developing different levels of enrollment; 2) making case management a time limited service for each enrolled family. While placing increased emphasis on short-term technical assistance, the model continues to emphasize the long-term relationship between case manager and family. Furthermore, isolation of the service from health care or other larger systems limits family awareness of availability. Most doctors have little (if any) awareness, since the program is not linked to them in any direct way. Few schools are aware of the program and those school personnel who are, have little sense of who is eligible, how they access the service, when it is appropriate to refer. Major sources of referral are limited to NICUs, EI programs, and word of mouth from other parents. Even then, most are not fully aware of the range of issues on which help is available. Therefore, the Division is planning a major change in the program. See annual plan, Table NPM-1D, for further discussion of proposed changes in this program. 	E

NPM #2 – The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Status of Annual Performance Indicator: 9

Indicator has: Improved Stayed the same Not Improved
Objective Met/Exceeded: Yes No

Source of Data: State CSHCN Program

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-2A. Programs to be reviewed/ revised are in Table NPM-2B.

TABLE NPM-2A

Programs/Activities Contributing to Success of NPM #2

Programs/Activities	Pyramid
Division of Special Health Needs Programs, including:	
Early Intervention	D, E
Family & Community Support <ul style="list-style-type: none"> Expanded implementation of hospital out-stationing of case managers; began SE Regional Team, an interagency group coordinating case management in shared complex cases 	E
Growth & Nutrition	D
MassCARE <ul style="list-style-type: none"> Initiated Mass. Consortium for CHSCN which focuses on managed care & expanded case management 	E
Mass. Genetics Program <ul style="list-style-type: none"> Presentations and trainings related to genetics counseling and services to improve community based genetics services and to support linkages 	I
MASSTART	I, E
Special Medical Fund, including hearing evaluations	D
Enhanced School Health Services	I, E

TABLE NPM-2B**Programs/Activities Needing Review/Revision for NPM #2**

Programs/Activities	Pyramid
Family & Community Support <ul style="list-style-type: none"> • Size & scope of the program is limited. <i>See additional discussion in Table NPM-1B and Table SPM-2B.</i> 	E

NPM #3 – The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”
--

Status of Annual Performance Indicator: 64.2%

Indicator has: () Improved (X) Stayed the same () Not Improved
 Objective Met/Exceeded: (X) Yes () No

Source of Data: State CSHCN Program – parent surveys

The method of calculating this measure has been changed as of this report (*see ERP notes for detail*)

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-3A. Programs to be reviewed/revise are in Table NPM-3B.

TABLE NPM-3A**Programs/Activities Contributing to Success of NPM #3**

Programs/Activities	Pyramid
Family & Community Support	E
MassCARE	E
Early Intervention <ul style="list-style-type: none"> • <input type="checkbox"/> Programs prioritize and refer all enrolled children to primary care providers. 	E
Growth and Nutrition	E
Combined Primary Care Program	D
School Health Services - Enhanced School Health <ul style="list-style-type: none"> • A requirement of the program is to determine that each student has a primary care provider. Students and their families without a primary care provider are given information and resources to assist them in selecting an appropriate care provider. • An average of 8 students per month were referred to a new primary care provider; and 77.1 were referred to their existing PCP (total: 4409 referrals to new providers; 47,717 referrals to students' exiting providers). Approximately 24,000 children were identified as having chronic health problems. 	E
School Based Health Centers <ul style="list-style-type: none"> • <input type="checkbox"/> A requirement is to determine whether a student has a primary care provider at the time of registration. Students and their families without a primary care provider are given information and resources to assist them in selecting an appropriate care provider. 	E

Programs/Activities	Pyramid
MCH Home Visiting Programs <ul style="list-style-type: none"> ☐ Children’s and parents’ medical home is monitored and reported in the Data System at repeated intervals; programs assist families in establishing & maintaining relationship with primary care provider, and with transportation and other access issues to assure continuity in primary medical services ☐ Programs conduct regular developmental assessments on enrolled children using the Ages & Stages Questionnaire, making referrals and ensuring communication with primary care providers and Early Intervention programs when developmental concerns present ☐ FIRSTSteps programs have MCH nurses on staff/available to identify health needs & assist in health care related linkages and collaboration with the medical community ☐ DPH staff presented a workshop at the annual Family Support Institute entitled “Partnering with the Medical Community” to increase skills and knowledge of home visiting provider staff 	E
FOR Families <ul style="list-style-type: none"> • Home visitors and telephone counselors assist all referred families to obtain health insurance and connection with a primary health care provider for all family members, including CSHCN 	E
MaxCare	I
WIC <ul style="list-style-type: none"> • Assessment for and referral to on-going health care (medical home) is provided at all certification and re-certification appointments for all enrolled children • Coordination and referrals are core standards for annual site evaluation. 	E

TABLE NPM-3B

Programs/Activities Needing Review/Revision for NPM #3

Programs/Activities	Pyramid
MCH Home Visiting Programs <ul style="list-style-type: none"> ☐ Infants & toddlers jointly enrolled in Home Visiting and Early Intervention do not routinely have a common IFSP, which would enhance appropriate and complete information sharing with the child’s primary care provider 	E
Data Collection <ul style="list-style-type: none"> • Programs do not currently systematically assess the broader definition of “medical home”. The State does not currently have a mechanism to accurately assess the total CSHCN population in relation to this measure. 	I

NPM #4 –Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).

Status of Annual Performance Indicator: 100%

Indicator has: () Improved (**X**) Stayed the same () Not Improved
 Objective Met/Exceeded: (**X**) Yes () No

Source of Data: New England Newborn Screening Program

Population(s) served: (**X**) Pregnant Women, Mothers and Infants () Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-4A.

TABLE NPM-4A

Programs/Activities Contributing to Success of NPM #4

Programs/Activities	Pyramid
New England Newborn Screening Program	P
Mass. Genetics Program	I
<ul style="list-style-type: none"> • Provided technical assistance to health care professionals, including hospitals and health center staff related to genetics education and program development 	

NPM #5 –Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B

Status of Annual Performance Indicator: 83%

Indicator has: (**X**) Improved () Stayed the same () Not Improved
 Objective Met/Exceeded: () Yes (**X**) No

Source of Data: Massachusetts Immunization Program

Population(s) served: (**X**) Pregnant Women, Mothers and Infants (**X**) Children () CSHCN

The target for this measure was set to match the Healthy People 2000 objective (see ERP notes), rather than a projection based on Massachusetts-specific indicators and influencing factors.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-5A. Programs to be reviewed/revised are in Table NPM-5B

TABLE NPM-5A**Programs/Activities Contributing to Success of NPM #5**

Programs/Activities	Pyramid
Children's Medical Security Plan (CMSP)	E
MCH Immunization Program, Combined Primary Care Program - Pediatric Component <ul style="list-style-type: none"> • <input type="checkbox"/> State and federal funding for childhood vaccines • <input type="checkbox"/> Inclusion of specific performance measures for contracting programs relevant to immunization • <input type="checkbox"/> Promoted collaboration between local WIC programs and primary care program contractors • <input type="checkbox"/> Provided technical assistance and education in contracting programs • <input type="checkbox"/> 75.88% of 2-year-olds served in 16 sites (outside the city of Boston) received the 4-3-3-3-1 series 	P
WIC <ul style="list-style-type: none"> • <input type="checkbox"/> Immunization assessment, education, referral, monitoring and follow-up are provided at all certification and re-cert. appointments of infants and children (a contract performance measure) • <input type="checkbox"/> Two immunization in-service education programs were conducted for local program staff • <input type="checkbox"/> Targeted technical assistance is provided to local programs when the % of 2 year olds who have completed the primary series is below the state average • <input type="checkbox"/> 87.7% of WIC enrolled children, ages 19-35 months, received the 4-3-3-3-1 series. This is the highest level in the nation for this cohort. 	P, E, I
MCH Home Visiting <ul style="list-style-type: none"> • Monitor immunization status of all children in enrolled families, provide education to parents on immunization, and assist families as needed to ensure that children are fully immunized. • <input type="checkbox"/> The Participant Data System (PDS) tracks immunization status of enrolled children • <input type="checkbox"/> Quarterly meetings between DPH Home Visiting staff and immunization staff were held, to provide appropriate immunization training, materials, and resources to home visitors and their supervisors • <input type="checkbox"/> Immunization staff conducted a survey of home visiting programs (100% response rate) to learn how home visitors collect immunization information, work with pediatricians, and use educational resources – for QI and TA purposes 	E, I
MaxCare <ul style="list-style-type: none"> • <input type="checkbox"/> Workshops on infection control, health and safety in child care, licensing updates and the impact of immunization regulations on child care promoted compliance with recommendations and regulations. • <input type="checkbox"/> Telephone technical assistance and mailed print materials were delivered to child care providers with specific questions and concerns about immunizations, vaccines, and vaccine-preventable diseases. • <input type="checkbox"/> 95.9% of children over age 2 who were enrolled in child care were fully immunized 	P, I
"Growing Up Healthy/Creciendo Sano," (the child health diary) <ul style="list-style-type: none"> • <input type="checkbox"/> Produced and released in English and Spanish to ensure age-appropriate access to and utilization of primary care, as well as to ensure age-appropriate, enhanced health supervision and content of care based on national Bright Futures Guidelines. Universal distribution through birthing hospitals was initiated. • Timely immunizations are addressed in the 15 well-child visit documentation pages, the inclusion of a special pocket for the Massachusetts Lifetime Immunization Record and a reminder card inserted into each book, and text describing the recommended schedule and listing vaccine-preventable diseases. 	P, I
Mass.Chapter of AAP-HMO meetings <ul style="list-style-type: none"> • Provides regular discussion time for new vaccines, variation among purchasers, and models for increasing rates. 	I

TABLE NPM-5B

Programs/Activities Needing Review/Revision for NPM #5

Programs/Activities	Pyramid
<p>MCH Immunization Program, Primary Care Services Pediatric Component</p> <ul style="list-style-type: none"> Data has not been available for CPCP sites in the city of Boston, but the program is working to address this The MCH Immunization Coordinator as a separate monitoring component for CPCP activities, in addition to program managers, was cumbersome in the program management process and may have diminished impact in some cases. This model has been changed, and the program management staff is assuming responsibility for immunization related activities, while the Immunization Program Coordinator continues to provide liaison support and coordination of activities Complete revision of the statewide immunization information system is being undertaken. 	I
<p>WIC</p> <ul style="list-style-type: none"> Inability to collect immunization data from some caretakers hinders WIC in making an accurate assessment of immunization status 	I
<p>MCH Home Visiting</p> <ul style="list-style-type: none"> Although the PDS is designed to collect immunization data and updates, technical problems with certain types of computer configurations at some program sites resulted in significant amounts of missing data. Therefore, accurate program data on participant children's immunization status is not available for FY99. This situation has now been corrected. 	I
<p>Factors affecting the overall rate, not specific to programs and activities</p> <ul style="list-style-type: none"> The immunization schedule continues to change frequently, e.g., adding varicella and removing rotavirus vaccines. High newcomer/immigrant population, and a high-risk homeless population in BFCH-contracting agencies. Many in these populations do not maintain well-child visits, and/or move frequently, thus not maintaining a timely immunization schedule Controversy about some new vaccines 	

NPM #6 – The birth rate (per 1,000) for teenagers aged 15 through 17 years.

Status of Annual Performance Indicator: 18.5

Indicator has: Improved Stayed the same Not Improved
 Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-6A. Programs to be reviewed/revision are in Table NPM 6B.

TABLE NPM-6A**Programs/Activities Contributing to Success of NPM #6**

Programs/Activities	Pyramid
<p>Family Planning</p> <ul style="list-style-type: none"> • DPH site visits to all programs focused on ensuring compliance with program standards, including specific standards on services to adolescents • Ongoing collaboration with Keep Teens Healthy, a Medicaid sponsored program providing family planning outreach to high-risk teens 	D, E, I
<p>Teen Pregnancy Prevention Challenge Fund</p> <ul style="list-style-type: none"> • Implementation of 9,365 on-going primary prevention activities in 17 selected communities with high teen birth rates, serving a total of 128,806 youth participants on health topics including alcohol/other drugs, dating violence, HIV/AIDS, STDs, human sexuality, reproductive health, life opportunities, and overall community health • Implementation of 7,964 one-time primary prevention activities in 17 selected communities with high teen birth rates, serving a total of 166,567 participants, including youth, parents and other community members • Funding of 4 school-based abstinence programs in Orange, Lawrence, Pittsfield and North Adams targeting primarily middle school youth through strategies such as Baby-Think-It-Over, School-based health education, skill-building and mentoring programs. • Implementation of the following steps in the process and outcome evaluation of three selected Teen Challenge Fund communities: <ul style="list-style-type: none"> ➤ establishment of evaluation teams in each of three selected communities ➤ development of coalition maps to define coalition strategies and long-term and intermediate outcomes ➤ establishment of focus and scope of evaluation 	P, E, I
<p>Abstinence Education Campaign</p> <ul style="list-style-type: none"> • Developed and broadcast 2 television ads targeting pre-adolescents and parents, and 7 radio ads for adolescents and parents. Using literature search and focus groups research, the messages were designed to meet the following Federal legislative mandates: <ul style="list-style-type: none"> ➤ Increase self-esteem and a sense of future self-sufficiency in pre-adolescents ➤ Support parents to instill positive values and set clear limits and behavioral expectations for their children • Produced television and radio messages; a teen brochure with information and skills to build self-confidence and overcome peer pressure, & encouraging teens to take pride in choosing abstinence; a parent brochure stressing early, on-going, & open communication with their children about sexual issues. • Distributed teen brochures and other collateral items for youth (shoe laces, neck-chains etc.) with the logo NO SEX NO PROBLEM! at multiple statewide events (health fairs, conferences, religious institutions, school based health clinics); radio sponsorship of concerts & basketball contest 	P
<p>MCH Home Visiting Programs</p> <ul style="list-style-type: none"> • Enhanced collaborative efforts with Family Planning Program, at DPH and on the local level • Family planning is documented and monitored in the participant data system 	E

Programs/Activities	Pyramid
School-Based Health Centers <ul style="list-style-type: none"> • Provide ongoing health education, counseling/support and pregnancy prevention services In addition to providing anticipatory guidance, clinical staff assess and counsel students at risk for pregnancy. • Distribute written pregnancy prevention materials (from Challenge Fund) • Performance measure requires 1) at least 85% of registered users are assessed for sexuality risk factors and 2) 100% of the students determined to be a risk for pregnancy are counseled on means to avoid pregnancy. 	E, D
Combined Primary Care Program: Adolescent Component <ul style="list-style-type: none"> • Ten agencies contract to provide Pediatric and Adolescent Specialty comprehensive primary care services, including counseling and family planning. 	D, E
Enhanced School Health Services	P, E, I
WIC Enrolled postpartum teens and teen mothers are referred to local family planning programs and other health and social services	E

TABLE NPM-6B

Programs/Activities Needing Review/Revision for NPM #6

Programs/Activities	Pyramid
Family Planning <ul style="list-style-type: none"> • <input type="checkbox"/> Reduced funding due to the utilization of a add-on visit rate reduced the number of adolescents that could be served in the program 	D
MCH Home Visiting Programs <ul style="list-style-type: none"> • Multiple implementation issues facing the Healthy Families Program resulted in inconsistent attention to family planning • Improve home visitor training to include stronger family planning component 	E, I
School-Based Health Centers <ul style="list-style-type: none"> • The scope of pregnancy prevention services provided on site in the school is determined and dependent upon the guidelines set by local school district/school committee 	P
Combined Primary Care Program <ul style="list-style-type: none"> • Provide TA to sites in ways to increase adolescent attendance for preventive well-child-care services • Mechanisms for tracking past care, and maintaining coordination for future care are insufficient for children in state custody • Plan to address barriers for teens: inaccurate perception that they are not eligible for insurance enrollment & services in their own right; confusion about care for emancipated minors and for homeless youth 	D, E

NPM #7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Status of Annual Performance Indicator: 21.6%

Indicator has: (X) Improved () Stayed the same () Not Improved
 Objective Met/Exceeded: (X) Yes () No

Source of Data: School-based Surveys

Data on the use of sealants are based on school-based surveys in only a few communities. Statewide data or survey findings are not available. See ERP notes for more detail.

Population(s) served: () Pregnant Women, Mothers and Infants (X) Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-7A. Programs to be reviewed/revised are in Table NPM-7B.

TABLE NPM-7A

Programs/Activities Contributing to Success of NPM #7

Programs/Activities	Pyramid
Office of Oral Health <ul style="list-style-type: none"> Expanded currently limited data on oral health. In addition to BRFSS, collected three school based oral health surveys The Office also worked with the DMA and private dental insurers to gather oral health data. A pilot sealant program provided protective sealants at Quinsigamond Community College's Dental Hygiene Clinic. 	P, I

TABLE NPM-7B

Programs/Activities Needing Review/Revision for NPM #7

Programs/Activities	Pyramid
Office of Oral Health <ul style="list-style-type: none"> Due to financial constraints, our state lacks a statewide oral health surveillance system to provide pertinent data for the planning and development of statewide oral health prevention programs, including protective dental sealants. 	P, I
Other factors impacting this performance measure, not directly related to programs: <ul style="list-style-type: none"> There is limited access to preventive oral health services including dental sealants for children who are under or uninsured. Medicaid-eligible children are especially unable to access these services, as the number of MassHealth providers is diminishing. Sealants are not a routine practice of oral health providers 	

NPM #8 – The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Status of Annual Performance Indicator: 0.96 / 100,000

Indicator has: Improved Stayed the same Not Improved
 Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-8A. Programs to be reviewed/revised are in Table NPM-8B.

TABLE NPM-8A

Programs/Activities Contributing to Success of NPM #8

Programs/Activities	Pyramid
Injury Prevention and Control Program – Safe on The Move <ul style="list-style-type: none"> Monthly facilitation of the Partnership for Child Passenger Safety. Staffed toll-free passenger safety technical assistance phone line. Distributed child passenger safety materials and information to 400 providers, 4 times per year. Staff person trained as certified child passenger safety technician 	P, I

Programs/Activities	Pyramid
School-Based Health Centers <ul style="list-style-type: none"> Elementary school sites have a performance measure that requires 1) at least 85% of registered users be assessed for safety risk factors and 2) 100% of the students determined to be at risk for injury be counseled on seat belt use. 85% of elementary students who received services at a School-Based Health Center program were counseled about the use of seat belts. Worked with DPH Injury Prevention program staff to survey SBHC primary care staff about their practices and training and resource materials needs to provide injury prevention services 	E, I
School Health Services / Enhanced School Health <ul style="list-style-type: none"> Training and information for school districts 	I
"Growing Up Healthy/Creciendo Sano" (The Child Health Diary) <ul style="list-style-type: none"> Child passenger safety is addressed in sections from newborns through age 6. Additional resources assist parents in obtaining information about car seat recalls, loan programs, and other passenger safety information. 	P, I
MCH Home Visiting Programs <ul style="list-style-type: none"> Home visitors provide passenger safety information and education to parents; assist parents in obtaining a car seat and provide information on its correct and safe use. 	E
Combined Primary Care Program <ul style="list-style-type: none"> Education on passenger safety is provided to parents 	E
WIC <ul style="list-style-type: none"> Education on passenger safety is provided to parents 	E
MaxCare <ul style="list-style-type: none"> Education on passenger safety is given to child care providers 	I

NPM #9 – Percentage of mothers who breastfeed their infants at hospital discharge.

Status of Annual Performance Indicator: 70.9%

Indicator has: Improved Stayed the same Not Improved
Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-9A. Programs to be reviewed/revised are in Table NPM-9B.

TABLE NPM-9A**Programs/Activities Contributing to Success of NPM #9**

Programs/Activities	Pyramid
WIC <ul style="list-style-type: none"> • 1998 Pregnancy Nutrition Surveillance System WIC data: 56.3% (N=13,425) of enrolled women initiated breastfeeding. Breastfeeding initiation rates are a contract performance measure. • All prenatal women were counseled on the benefits of breastfeeding, and incentives provided. • Prenatal infant feeding groups emphasized the benefits of breastfeeding • Local programs celebrated World Breastfeeding Week with a many promotional activities and media coverage, including health fairs, baby showers, fashion shows, and trainings for health care providers. • USDA “Loving Support Makes Breastfeeding Work” promotion campaign materials were used by local programs for participant education. • The Breastfeeding Promotion Task Force met regularly to address increasing initiation rates • The “Mother to Mother” Breastfeeding Peer Counselor Program functioned to promote breastfeeding to pregnant women. • The Breastfeeding Basics and Advanced trainings for paraprofessional and professional staff • Breastfeeding promotion information was developed and distributed to participants; training materials were developed and distributed to nutrition staff. • Local programs employed 11 International Board Certified Lactation Consultants and 16 CLCs 	E, I
Combined Primary Care Programs: Perinatal Component <ul style="list-style-type: none"> • <input type="checkbox"/> Conducted statewide breastfeeding education activities • <input type="checkbox"/> Improved coordination at the state and local levels with the WIC program • <input type="checkbox"/> Included breastfeeding rates in the performance measures for the programs • <input type="checkbox"/> Breastfeeding rate was 64.9% in DPH funded primary care programs 	E, I
Healthy Start <ul style="list-style-type: none"> • Prenatal education, including breastfeeding and WIC, are mailed to enrolled pregnant women • Referrals to WIC are made by Health Access specialists in phone contacts with pregnant women 	E
MCH Home Visiting Programs – Healthy Families (HF) and FIRSTSteps (FS) <ul style="list-style-type: none"> • <input type="checkbox"/> Core home visitor training includes breastfeeding education. • <input type="checkbox"/> Enhanced relationships with WIC program staff at the local level • <input type="checkbox"/> DPH staff presented at statewide WIC coordinator meetings and at statewide nutritionist meetings to facilitate more effective linkages between the programs. • <input type="checkbox"/> Communication with WIC staff when referrals between the programs appeared lower than expected and developed appropriate strategies • <input type="checkbox"/> Breastfeeding information is collected and monitored through the data system. For HF, 55.6% breastfed their infants; compared to 54.8% of teen mothers statewide. In FS, the percentage of mothers who breastfed was 55.9%. 	E, I
“Growing Up Healthy/Creciendo Sano” (child health diary) <ul style="list-style-type: none"> • <input type="checkbox"/> Six pages encourage, instruct, and support parents to choose breastfeeding. Resource section identifies lactation resources. Prenatal distribution through WIC and home visiting programs. 	P, I

TABLE NPM-9B**Programs/Activities Needing Review/Revision for NPM #9**

Programs/Activities	Pyramid
WIC <ul style="list-style-type: none"> • <input type="checkbox"/> Additional breastfeeding training is needed for MCH nutritionists and other medical providers 	I
Combined Primary Care Programs: Perinatal Component <ul style="list-style-type: none"> • <input type="checkbox"/> Reliability and consistency of data collection at the local programs has varied significantly. Reporting is done through a paper system, which needs to be updated and converted to an electronic data reporting system that is geared to the providers’ needs 	E

NPM #10 – Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Status of Annual Performance Indicator: 85.2%

Indicator has: Improved Stayed the same Not Improved
 Objective Met/Exceeded: Yes No

Source of Data: Surveys of birth hospitals; BFCH analysis

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

In Massachusetts, Chapter 243 of the Acts of 1998, An Act Providing for Hearing Screening of Newborns, was passed on August 7, 1998 and became effective on November 7, 1998. The Universal Newborn Hearing Screening Law, as the Massachusetts statute is known, mandates that a hearing screening be performed on every newborn in the Commonwealth of Massachusetts prior to discharge from a hospital or birth center. The law also mandates that the Department of Public Health promulgate regulations for universal newborn hearing screening.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-10A. Programs to be reviewed/revised are in Table NPM-10B.

TABLE NPM-10A
Programs/Activities Contributing to Success of NPM #10

Programs/Activities	Pyramid
<p>Universal Newborn Hearing Screening Program</p> <ul style="list-style-type: none"> • <input type="checkbox"/> In January 1999, the Department established a multi-disciplinary Advisory Committee to develop amendments to the Hospital Licensure Regulations (105CMR 130.000) and Birth Center Licensure Regulation (105 CMR 142.000) to include information about universal newborn hearing screening. The Advisory Committee met regularly and drafted regulations that were presented at a Public Hearing on June 1, 1999. (approved in FY2000) • <input type="checkbox"/> During FY99, the Universal Newborn Hearing Screening Program began writing guidelines for hospital screening protocols. These guidelines will be used by hospitals to write their screening protocols, which must be submitted to DPH for approval. • <input type="checkbox"/> Three subcommittees related to Newborn Hearing Screening were formed: 1) Hospital Guidelines, 2) Follow-up and tracking, and 3) Approved Diagnostic Centers. These committees laid the groundwork for writing the hospital guidelines, writing guidelines for approved diagnostic centers, and writing a plan to begin tracking newborns through the electronic birth certificate system. 	<p>P, I</p>

NPM #11 – Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Status of Annual Performance Indicator: 97%

Indicator has: () Improved (X) Stayed the same () Not Improved
 Objective Met/Exceeded: (X) Yes () No

Source of Data: BFCH Program Data

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-11A. Programs to be reviewed/revised are in Table NPM-11B

TABLE NPM-11A
Programs/Activities Contributing to Success of NPM #11

Programs/Activities	Pyramid
SSI and Public Benefits Outreach, Training, Technical Assistance and Policy Activities <ul style="list-style-type: none"> • Train the Trainer series on SSI and Public Benefits at regional locations around the state • Ongoing regular training programs for Early Intervention programs, hospital staff, case managers, community health providers, human services providers, parents and family homeless shelter staff on the eligibility and application process for public benefits of SSI, CommonHealth, CMSP, MassHealth and Kaileigh Mulligan Home Care Program. (total of 21 trainings, with 231 participants) • Chaired a statewide SSI Networking Group (have established key contacts in each region of the state) with quarterly meetings and mailings regarding updates and information on SSI and Public Benefits (2 quarterly meetings held and 115 mailings of materials) • Participated in an SSI Advocacy Coalition, DDS Advisory Council, Statewide Advisory Council for Special Education, and Children's Health Access Coalition • Responded to technical assistance requests received by toll-free or local phone lines (176) 	I, E
Early Intervention Program <ul style="list-style-type: none"> • <input type="checkbox"/> Before an EI program can be paid with DPH state funds, referral must be made to MassHealth. • <input type="checkbox"/> 97% of enrolled children are insured by Medicaid (MassHealth) or private insurance 	E
MassCARE <ul style="list-style-type: none"> • 96% of enrolled children are insured by Medicaid (MassHealth) or private insurance 	E
Growth and Nutrition Program <ul style="list-style-type: none"> • Families of all enrolled children are given information on insurance and enrollment. 100% of enrolled children have a primary care provider (a medical home) in place. • Program intake form records insurance and medical home to facilitate monitoring of this measure 	D
Family & Community Support <ul style="list-style-type: none"> • <input type="checkbox"/> Provides case management & assistance to families to enroll in public benefits programs 	E
School Health Services / Enhanced School Health	E
School-Based Health Centers <ul style="list-style-type: none"> • <input type="checkbox"/> A performance measure requires SBHCs to determine insurance status at registration. Children and their families without insurance are assisted in enrolling in an insurance plan. • <input type="checkbox"/> Worked with DMA to provide training and information to all SBHC staff about the publicly funded insurance plans; supplied sites with application materials to the MassHealth and CMSP • <input type="checkbox"/> 22% of children self reported as having a chronic / on-going health problem were not insured 	E
FOR Families <ul style="list-style-type: none"> • Referred families of CSHCN to case management program and for SSI application assistance. 	E
WIC <ul style="list-style-type: none"> • Families of all enrolled children are given information on health insurance and how to enroll. 	E

TABLE NPM-11B

Programs/Activities Needing Review/Revision for NPM #11

Programs/Activities	Pyramid
School-Based Health Centers: <ul style="list-style-type: none"> <input type="checkbox"/> Current tracking system does not allow follow-up on these specific children. 	E

NPM #12 – Percent of children without health insurance.

Status of Annual Performance Indicator: 2.7%

Indicator has: Improved Stayed the same Not Improved
Objective Met/Exceeded: Yes No

Source of Data: 1999 Massachusetts BRFSS

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-12A.

TABLE NPM-12A

Programs/Activities Contributing to Success of NPM #12

Programs/Activities	Pyramid
Children’s Medical Security Plan (CMSP) <i>This was the first operational year of the MassHealth expansion</i> <ul style="list-style-type: none"> Health Access Network formed Transferred eligible families to MassHealth; increased focus on families over 200% FPL Outreach grants to community-based providers to find and enroll eligible children 	E, I
Combined Primary Care Programs – Pediatric and Adolescent Components <ul style="list-style-type: none"> Financial screening and support services to ensure clients are enrolled in appropriate health insurance. Many Community Health Centers used DPH Support and Enhancement funding to strengthen support of financial counseling staff and include innovative follow-up activities 	E
School Health/Enhanced School Health <ul style="list-style-type: none"> <input type="checkbox"/> Worked closely with the DMA and the University of Massachusetts Health Care Finance to a) ensure that families receive information about MassHealth through the schools, and b) encourage all school systems to participate in Municipal Medicaid, Part B, Coordination and Outreach Services. DMA sent letters through the schools to all parents about the availability of CMSP and MassHealth. <input type="checkbox"/> Through the quarterly newsletter, <i>News in School Health</i>, (circulation 3500—superintendents, school nurses, school physicians, boards of health, etc.) schools were encouraged to review health insurance status at entry into school, providing referrals as needed; include a statement on the emergency card, signed by the parents, asking about the need for health insurance and advising them to call the school nurse for more information <input type="checkbox"/> Included information on public health insurance programs at local health fairs. <input type="checkbox"/> A performance measure is to identify all uninsured children and facilitate referrals & enrollment <input type="checkbox"/> 240 school districts have begun to participate in Part B of Municipal Medicaid 25 school districts referred 4,663 uninsured students to health insurance providers (MassHealth and Children's Medical Security Plan). The average number of referrals per month for the median district was 10.3 students per month; the median monthly referral rate was 2.9 per 1000 students. 	E, I

Programs/Activities	Pyramid
School-Based Health Centers <ul style="list-style-type: none"> <input type="checkbox"/> A performance measure requires eligible children/families be assisted in applying for insurance. <input type="checkbox"/> In FY 99, 12.8% of children served by School-Based Health Centers did not have health insurance (a 2% improvement from FY98) <input type="checkbox"/> Worked with the DMA to provide training and information to all SBHC staff about publicly funded insurance plans; supplied sites with application materials for MassHealth and CMSP 	E
MCH Home Visiting Programs <ul style="list-style-type: none"> <input type="checkbox"/> Home visitors received training on assisting with insurance and health care access <input type="checkbox"/> Refer and assist families without health insurance to enroll in MassHealth or CMSP <input type="checkbox"/> The insurance status of enrolled children is documented and monitored through the data system <input type="checkbox"/> Worked to enhance collaboration with Health Access Unit in BFCH <input type="checkbox"/> Healthy Start added the home visiting programs on their screening forms <input type="checkbox"/> DPH staff attend biweekly perinatal workgroup meetings with DMA. 	E
Early Intervention <ul style="list-style-type: none"> <input type="checkbox"/> All children are screened for health insurance at enrollment, and all uninsured are encouraged and assisted to apply for MassHealth 	E
FOR Families <ul style="list-style-type: none"> Outreach and referrals to families with children for MassHealth, CMSP and Healthy Start. 	E
MaxCare <ul style="list-style-type: none"> <input type="checkbox"/> All workshops included education on enrollment in state insurance programs. <input type="checkbox"/> Health Access Outreach mini-grants awarded to 5 child care-related agencies 	I
WIC <ul style="list-style-type: none"> Information & referrals on insurance enrollment provided to uninsured enrolled women and children 	E
Teen Pregnancy Prevention Challenge Fund <ul style="list-style-type: none"> 319 on-going activities specifically focused on health insurance, serving a total of 1,072 youth 60 community-based one-time activities focused on health insurance, serving a total of 477 youth 	E
“Growing Up Healthy/Creciendo Sano” (child health diary) <ul style="list-style-type: none"> Health insurance access is addressed in 3 pages, with a comprehensive list of resources 	P, I

TABLE NPM-12B

Programs/Activities Needing Review/Revision for NPM #12

Programs/Activities	Pyramid
Teen Pregnancy Prevention Challenge Fund <ul style="list-style-type: none"> Need to increase technical assistance to contractors re: targeted outreach efforts 	I, E

NPM #13 – Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Status of Annual Performance Indicator: **81.9%**

Indicator has: () Improved (X) Stayed the same () Not Improved
Objective Met/Exceeded: (X) Yes () No

Source of Data: Division of Medical Assistance (DMA) - MassHealth

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-13A. Programs to be reviewed/revise are in Table NPM-13B.

TABLE NPM-13A**Programs/Activities Contributing to Success of NPM #13**

Programs/Activities	Pyramid
Combined Primary Care Program – Pediatric and Adolescent Components	D
School Based Health Centers <ul style="list-style-type: none"> • Provide direct health care services • Provided training, in conjunction with DMA, to SBHC providers, including information about the availability of software that would allow sites to obtain current MassHealth eligibility data at the time of the encounter 	D, I
School Health Services / Enhanced School Health <ul style="list-style-type: none"> • The majority of school districts participate in Part B of Municipal Medicaid, and are reimbursed for health services to MassHealth eligible children • <input type="checkbox"/> Worked closely with DMA to craft information to program participants regarding well child visits and the need for anticipatory guidance. • <input type="checkbox"/> Worked with the Massachusetts Committee of School Physicians to begin to craft a template for the role of the school physicians. In the template, schools are encouraged to reduce or eliminate the number of "sports" physical examinations done in the schools; the students should be referred to primary care providers now that health insurance is available for all children. 	D, I
Massachusetts Bright Futures Campaign	I
WIC <ul style="list-style-type: none"> • Referrals to health care providers for enrolled children. Provision of referrals is a core standard for site evaluation. • Require evidence of immunization and preventive medical care. Immunization rates are a contract performance measure. 	E
MCH Home Visiting Programs <ul style="list-style-type: none"> • Home visitors assist parents with barriers to access to care, such as transportation and child care; some programs transport enrolled parents and children to medical appointments • Referrals made to primary and specialty health care providers 	E, D
Family & Community Support <ul style="list-style-type: none"> • <input type="checkbox"/> Provided MassHealth enrollment assistance for children with special health care needs 	E
CMSP <ul style="list-style-type: none"> • All children are first screened for MassHealth eligibility (Medicaid and SCHIP programs), so that Medicaid-eligible children are enrolled appropriately in MassHealth. Only children denied MassHealth are then enrolled in CMSP. Continued collaboration with MassHealth will ensure that the appropriate programs are responsible for payment for services rendered to enrollees in both MassHealth and CMSP. 	E
Early Intervention <ul style="list-style-type: none"> • All enrolled children are assisted with barriers to access to health care and services • Referrals made to primary and specialty health care providers as needed 	E
FOR Families <ul style="list-style-type: none"> • Home visitors assist families with barriers to access to health care and services • Referrals made to primary and specialty health care providers as needed 	E

TABLE NPM-13B**Programs/Activities Needing Review/Revision for NPM #13**

Programs/Activities	Pyramid
School Based Health Centers <ul style="list-style-type: none"> • <input type="checkbox"/> The current cost reimbursement and data collection systems do not allow proper tracking for collection of billing data at DPH. 	I

NPM #14 – The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Status of Annual Performance Indicator: 13

Indicator has: () Improved (X) Stayed the same () Not Improved
 Objective Met/Exceeded: () Yes (X) No

Source of Data: State CHSCN Program – Parent Initiatives

This measure is scored by the Parent Initiatives coordinators.

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Please see Table NPM14C in the annual Plan for planned activities and strategies to improve this measure.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-14A.

TABLE NPM-14A
Programs/Activities Contributing to Success of NPM #14

Programs/Activities	Pyramid
<p>Division for Special Health Needs</p> <ul style="list-style-type: none"> • Family members participate on advisory committees or task forces and are offered training, mentoring and reimbursement. <ul style="list-style-type: none"> ➤ Participation of families as advisors on program planning and policy issues continuously sought. The Family TIES parents act as conduits to engage and mentor other parents in Division advisory activities on both the regional and statewide levels. These advisory activities are typically time-limited and parents are reimbursed for their expenses. ➤ Active and continuous participation of parents on the statewide Early Intervention Interagency Coordinating Council (ICC) and its related committees. Seven parents, who represent the diverse service population, sit as regional representatives on the ICC and approximately one dozen other parents participate on the ICC committees. Parents were reimbursed for their expenses related to these activities and provided mentoring through a paid parent who coordinates the EI Parent Leadership Project. ➤ All certified early intervention programs are required to provide multiple and varied opportunities for a diverse and representative number of families to participate as advisors in the development and monitoring of program policies, procedures, and practices. <i>“Working Together”</i> (published in January 1997), a booklet of resources on family participation has continued to be used to assist staff and family members in their efforts. In addition, the interactive training entitled <i>“Essential Allies”</i> is provided at 12 EI program sites to assist in facilitating family participation in advisory roles at the local level. ➤ The MassCARE project had full task force participation by parents. • Financial support (financial grants, technical assistance, travel and child care) is offered for parent activities or parent groups. <ul style="list-style-type: none"> ➤ Direct financial support for the expenses of family members involved in any advisory activity. ➤ Subsidies for attendance of a large number of parent representatives at the two day annual Early Intervention conference ➤ Financial support for the annual Family TIES Conference attended by almost 500 family members and providers. The conference, “There’s Room for All of Us” was sponsored in collaboration with the Federation for Children with Special Needs and Parent Advocacy League (PAL), which represents parents of children with mental health needs. • Family members are involved in the Children with Special Health Care Needs’ elements of the block grant. 	<p>I, E</p>

Programs/Activities	Pyramid
<ul style="list-style-type: none"> ➤ Because of the intrinsic nature of family participation in all aspects of the DSHN activities, families are indirectly involved in the block grant process; families are consistently involved as advisors on the development and implementation of all DSHN programs. ➤ Family TIES parent coordinators were directly involved in the assessment of our progress in meeting the CSHCN performance measures, setting future objective targets, and in identifying areas in need of improvement – principally increasing the cultural diversity of parent involvement. • Family members are involved in in-service training of CSHCN staff and providers. <ul style="list-style-type: none"> ➤ Formal and informal consultation and collaborative training on an ongoing basis through Family TIES parent coordinators located in each regional office. ➤ Parent coordinators consult to other DSHN staff regarding the family perspective on policy and practice, drawing from their personal experience and the knowledge they gain from their regional and statewide networks. ➤ Parent coordinators also participate in regional and statewide training sessions with other CSHCN staff. ➤ Parent staff from the EI Parent Leadership Project, provide the “Essential Allies” training (mentioned above) which requires an equal number of parent and professional staff participants. Five additional parents were trained to present this training during FY99. • Family members are hired as paid staff or consultants to the state CSHCN program. <ul style="list-style-type: none"> ➤ The many parent positions in the DSHN and their roles are described in Section 1.5.1.3. • Family members of diverse cultures are involved in all of the above activities. <ul style="list-style-type: none"> ➤ Outreach efforts to families of diverse cultures continued during FY99. ➤ Targeted effort was made to bring Spanish and Portuguese speaking families to the annual Family TIES conference, “There’s Room for All of Us” (see above) and to provide opportunities for education and networking in their native language. Special workshops were offered in Spanish and Portuguese and interpreters were available for Spanish, Portuguese, Vietnamese, and ASL. ➤ The MassCARE project continued to exhibit exceptional cultural diversity, employing peer advocates who are women of color living with HIV/AIDS and maintaining high participation of families of diverse cultures in its Family Advocate Network and related activities. 	
<p>Family TIES</p> <ul style="list-style-type: none"> • Through a competitive RFR process, a new contract for the Family TIES project was established with the Federation for Children with Special Needs (FCSN). The coordinators had already been employees of the FCSN, but this closer affiliation led to enhanced collaboration with the other parents and projects at the FCSN and their rich history and expertise. • A Web site [http://www.massfamilyties.org] provides parents and providers with up-to-date information on services, supports and personal experiences from early intervention through the transition into adult services. This site changed providers in FY99 and is operated in collaboration with the FCSN. This provides access to an increased number of resources; hyper-links to frequently used sites; and allows the full publication of the Family TIES resource directory on the website. • Increased visibility of the Family TIES 800-line, especially targeted to Early Intervention, with resulting dramatic increases in the volume of calls and of referrals by Family TIES coordinators to EI (up from 71 in FY98 to 152 in FY99) • Continued efforts to improve Parent to Parent materials and database to match experienced parents with those seeking support. Increased requests for matches for rare disabilities were noted, with national groups that were once able to make these matches either non-responsive or underfunded. Thirty-four parent-to-parent matches were made. 	I, E
<p>Mass Consortium for CSHCN (collaboration with providers and Family Voices)</p>	I, E

NPM #15 – The rate (per 100,000) of suicide deaths among youths 15-19.

Status of Annual Performance Indicator: 6.57 / 100,000

Indicator has: () Improved () Stayed the same (X) Not Improved
 Objective Met/Exceeded: () Yes (X) No

Source of Data: MDPH Vital Records

Population(s) served: () Pregnant Women, Mothers and Infants (X) Children () CSHCN

The BFCH has identified both mental health and suicide as a major priority need area. See Tables NPM-15C, SPM-12C, PN-7, and PN-8 in the Annual Plan for planned activities in FY01 to address this measure.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-15A. Programs to be reviewed/revised are in Table NPM-16B.

TABLE NPM-15A
Programs/Activities Contributing to Success of NPM #15

Programs/Activities	Pyramid
<p>Injury Prevention and Control</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Organized statewide Violence Prevention Month activities. • <input type="checkbox"/> Hosted first annual Mass. Suicide Prevention Awareness Day at the Statehouse • <input type="checkbox"/> Helped to establish the Mass. Alliance of Samaritans Services, a coalition of state chapters • <input type="checkbox"/> Co-hosted statewide meeting on suicide prevention in Worcester, MA • <input type="checkbox"/> Facilitated the Region I breakout group at the National Conference on Suicide Prevention • <input type="checkbox"/> On invitation, submitted a CDC Conference Support Grant for Northeast Injury Prevention • <input type="checkbox"/> Received a \$4,000 seed money grant from the Harvard Injury Resource Center to explore mental health data sources on suicide attempts • <input type="checkbox"/> Obtained funding to produce a Bi-regional data book on suicide, for HHS Regions I and II. • <input type="checkbox"/> Planning a Suicide Prevention Planning Conference for HHS Regions I and II (June 2000) • <input type="checkbox"/> Began a data report on Suicide in Massachusetts • <input type="checkbox"/> Presented data and information on suicide at 15 different meetings and/or conferences. • <input type="checkbox"/> Hosted Dr. Lloyd Potter from CDC to talk about national efforts in suicide prevention • <input type="checkbox"/> Coordinated and hosted monthly meetings of DPH Violence Prevention Working Group. 	<p>I</p>
<p>School-Based Health Centers</p> <ul style="list-style-type: none"> • <input type="checkbox"/> DPH standards require sites to provide mental health services directly or through arrangement. Programs perform behavioral risk assessments that include emotional health risk factors. • <input type="checkbox"/> 22.3% of SBHC visits in FY99 were for emotional problems. Each SBHC visit included at least one behavioral risk assessment. A total of 8 suicide attempts were reported by SBHCs. 	<p>D, I</p>
<p>School Health</p> <ul style="list-style-type: none"> • <input type="checkbox"/> School Health Institute provided a program on Mental Health Problems in Children, which was attended by 45 school health staff (the majority nurses). 	<p>I</p>

TABLE NPM-15B
Programs/Activities Needing Review/Revision for NPM #15

Programs/Activities	Pyramid
Injury Prevention and Control <ul style="list-style-type: none"> <input type="checkbox"/> A lack of state funding for suicide prevention activities. 	I
School-Based Health Centers <ul style="list-style-type: none"> <input type="checkbox"/> Revise data collection system to allow specific data on depression. 	I

NPM #16 – Percent of very low birth weight live births.
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Status of Annual Performance Indicator: 1.3%

Indicator has: () Improved (**X**) Stayed the same () Not Improved
Objective Met/Exceeded: (**X**) Yes () No

Source of Data: MDPH Vital Records

Population(s) served: (**X**) Pregnant Women, Mothers and Infants () Children () CSHCN

<p>Although the objective for this measure was met, and the percentage is essentially the same as the previous year, trend data show that the percentage of VLBW births is rising. See Needs Assessment Section 3.1.2.1 for more discussion of this concerning finding, plus the narrative for this measure and Table NPM-16C in the annual plan.</p>

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-16A. Programs to be reviewed/revise are in Table NPM-16B.

TABLE NPM-16A
Programs/Activities Contributing to Success of NPM #16

Programs/Activities	Pyramid
Healthy Start Program	E
Combined Primary Care Program: Perinatal Component <ul style="list-style-type: none"> Many sites prioritized improving access and coordination of care at the time of a positive pregnancy test or first visit, to increase early and adequate prenatal care Improved prenatal nutrition education in many sites Improved coordination with WIC, as a result of a new performance measure for the CPCP 	E, I
WIC <ul style="list-style-type: none"> <input type="checkbox"/> Pregnant women receive a thorough nutrition assessment, and are prescribed an appropriate food package. In addition, pregnant women with poor weight gain patterns are monitored regularly and receive in-depth counseling and intervention plans. All pregnant women who smoke, or resume smoking during their pregnancy, are referred to smoking cessation programs. Provision and quality of nutrition services are core standards for site evaluation. <input type="checkbox"/> In 1998, 1.0% (N=306) of singleton births to women on WIC had very low birthweights. 	E
MCH Home Visiting Programs <ul style="list-style-type: none"> FS programs have MCH nurses, on staff or available to contribute to early identification, education and care coordination for high risk pregnant women. Home visiting staff received training on working with women during pregnancy around nutrition, smoking, and other factors that may contribute to VLBW 	E, I

Programs/Activities	Pyramid
MCH Health Education <ul style="list-style-type: none"> <input type="checkbox"/> In collaboration with 14 statewide perinatal advocacy and support organizations, held “Partners in Perinatal Health” annual conference, which reached a multidisciplinary audience of 400 providers. Provided up-to-date training and multidisciplinary networking opportunities for all levels of perinatal care providers. 	I
Infant Mortality Review Task Forces <ul style="list-style-type: none"> <input type="checkbox"/> Activities in Boston, Worcester and Springfield brought together key community stakeholders to discuss issues to extreme prematurity and VLBW, and develop community action plans. 	I
Triplets and More <ul style="list-style-type: none"> Meetings to review issues related to multiple births. Community by community review of birth data. Data review with identification of the role of infertility treatment, including Artificial Reproductive Technology, on multiple births and very low birthweight. Began planning to convene an Infertility Summit with parents, professionals, and organizations. 	I
<i>See also programs and activities in Table NPM-6A and Table SPM-5-A</i>	

TABLE NPM-16B

Programs/Activities Needing Review/Revision for NPM #16

Programs/Activities	Pyramid
Infant Mortality Review Task Force <ul style="list-style-type: none"> A statewide initiative might develop and coordinate strategies across communities. 	I

NPM #17 – Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Status of Annual Performance Indicator: 86.6%

Indicator has: () Improved () Stayed the same (X) Not Improved
Objective Met/Exceeded: (X) Yes () No

Source of Data: MDPH Vital Records

Population(s) served: (X) Pregnant Women, Mothers and Infants () Children () CSHCN

Although the State met the objective set for this measure, the data review and analysis showed distinct variations among regions of the state, particularly the Southeast which is notably lower than the other regions and the state as a whole. There is no tertiary care maternal-newborn hospital in this region of the state, and many high risk births and infants transfer to a tertiary center in Rhode Island. A majority of the Level I and II hospitals in this region have cooperative agreements with the Neonatology Department of that center. Therefore, all out-of-state births were excluded from this analysis, and the low rate (65.7%) persists. This finding is a concerning one, and has been discussed with the BFCH SE Regional Office manager. Additional study is needed to determine where these babies were born, and to discern the reasons for the low performance on this measure. This activity is planned for FY2001 (see additional note in Table NPM-17B).

Massachusetts undertook a major revision of the licensure regulations for Maternal-Newborn hospital facilities 10 years ago. Continued refinement of the regulations has occurred in the ensuing years through the state’s Perinatal Advisory Committee, joint committee BFCH and DPH Division of Health Care Quality. One of the most dynamic areas of study has been the Level II designation. These facilities are equipped to handle moderate risk deliveries and neonates, with collaborative agreements with neonatologists. The numerator of the calculation for this performance measure is currently defined as VLBW infants born at a Level III (i.e., tertiary care) facility. The Bureau plans to bring these new data to the committee, and facilitate further study and analysis of the definition of appropriate delivery site and of strategies to improve performance in the SE region.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-17A. Programs to be reviewed/revised are in Table NPM-17B.

TABLE NPM-17A

Programs/Activities Contributing to Success of NPM #17

Programs/Activities	Pyramid
Surveillance	P, I
Massachusetts Perinatal Advisory Committee <ul style="list-style-type: none"> Review of entire regional system; assessment of the need for changes in the system Worked with Health Care Quality to assure facilities are meeting licensure requirements 	I

TABLE NPM-17B

Programs/Activities Needing Review/Revision for NPM #17

Programs/Activities	Pyramid
Massachusetts Perinatal Advisory Committee <ul style="list-style-type: none"> Further systematic analysis and monitoring will be integrated into the work of the committee, including the definition of appropriate delivery site for high risk newborns (<i>see narrative above</i>) 	I
Southeast Regional Health Office <ul style="list-style-type: none"> The issue of delivery site for high risk infants has not been the focus of pregnancy outcome improvements, nor has it been addressed recently in the regional infant mortality task force. This group will reconvene and focus on the apparent low rate of this performance measure in this region. 	I

NPM #18 – Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Status of Annual Performance Indicator: 84.3%

Indicator has: Improved Stayed the same Not Improved
 Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table NPM-18A. Programs to be reviewed/revised are in Table NPM-18B.

TABLE NPM-18A**Programs/Activities Contributing to Success of NPM #18**

Programs/Activities	Pyramid
Healthy Start <ul style="list-style-type: none"> • <input type="checkbox"/> In June 1999, Healthy Start officially expanded its income eligibility guidelines to 225% FPL, in response to Health Care Reform that allowed MassHealth (Medicaid) to expand its coverage to 200% • <input type="checkbox"/> Letters were sent to all Healthy Start applicants/enrollees notifying them of the change in national policy regarding “Public Charge”. • <input type="checkbox"/> An educational publicity campaign was designed and implemented statewide to announce both the change in Healthy Start’s income guidelines, as well as clarification of the “Public Charge” issue. 	E, P
Combined Primary Care Program (CPCP): Perinatal Component <ul style="list-style-type: none"> • <input type="checkbox"/> Emphasis on culturally appropriate education and outreach, including maternal age and education • <input type="checkbox"/> This is a state contract performance measure • <input type="checkbox"/> 73.4% of women served received prenatal care in the first trimester 	D, E
WIC <ul style="list-style-type: none"> • <input type="checkbox"/> Prenatal women who enroll in WIC and are not receiving prenatal care are referred for such care immediately, regardless of trimester. Receipt of prenatal care is monitored at the next WIC visit. • <input type="checkbox"/> Percent of women enrolled early in pregnancy is a contract performance measure. 	E
Health Education <ul style="list-style-type: none"> • “Partners in Perinatal Health” Conference -- see NPM #15 	I

TABLE NPM-18B**Programs/Activities Needing Review/Revision for NPM #18**

Programs/Activities	Pyramid
CPCP – Perinatal Component <ul style="list-style-type: none"> • <input type="checkbox"/> Contracting agencies need improvements in reporting this information • <input type="checkbox"/> Improve outreach approach in areas with large newcomer or immigrant populations in which prenatal care is not part of the culture or lifestyle 	E, I
Healthy Start <ul style="list-style-type: none"> • <input type="checkbox"/> Data are not available for enrolled women. A match to the Birth file is currently being planned. 	I

State Performance Measures

SPM #1 – The percent of women in need of publicly funded contraceptive services receiving family planning and related reproductive health services through programs with MCH funding.

Status of Annual Performance Indicator: N/A

State Priority Need Being Addressed: #2: Improvements in pregnancy outcomes
#3: Reductions in adolescent risk factors and risk-taking behaviors

Population(s) served: () Pregnant Women, Mothers and Infants (X) Children (teens) () CSHCN
(X) Other (women of reproductive age)

This measure has been revised for FY2001. For further detail, see the discussion on unplanned pregnancy in the Needs Assessment Section 3.1.2.1 and State Performance Measure #11, with Table SPM-11C, in the Annual Plan.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table SPM-1A. Programs to be reviewed or revised are in Table SPM-1B.

TABLE SPM-1A
Programs/Activities Contributing to Success of SPM #1

Programs/Activities	Pyramid
<p>Family Planning Program</p> <ul style="list-style-type: none"> • Hired a consultant to develop an allocation methodology including assessment of community need for family planning services statewide. • Completed Family Planning Clients and HIV risk survey report. Findings included significant levels of HIV-related characteristics and risk behavior among respondents. This information has helped inform state policy makers of the critical need for HIV services in family planning programs. It has also informed providers of client needs with regards to service provision. • Collaborated with the State Family Planning Administrators to develop sample family planning performance measures including measures on family planning need. • Funded agencies continued to provide extensive outreach to schools, community organizations, housing developments, jails, substance abuse programs and other groups serving populations at risk for unintended pregnancy. • Increased options for contraceptives to males by expanding coverage to include vasectomies. • In May 1999 in collaboration with a provider agency, provided training on serving male clients to family planning counselors through Family Planning Counselor Breakfast series. • Began cost analysis project in collaboration with providers and Health Care Finance and Policy 	D, I, E
<p>Combined Primary Care Programs</p> <ul style="list-style-type: none"> • Contracted sites have a performance measure that requires service providers to ask women about family planning and to make referrals to a local family planning program, if the CPCP site does not provide the service directly. 	E
<p>MCH Home Visiting Program</p> <ul style="list-style-type: none"> • Provide family planning information & refer enrolled women to local family planning programs. • Home visitors in some sites have had special training and are certified family planning counselors. 	E, I
<p>WIC</p> <ul style="list-style-type: none"> • Enrolled women and mothers of enrolled children are referred to local family planning programs. 	E
<p>State Office of Rural Health</p> <ul style="list-style-type: none"> • Worked DPH Family Planning Program and the North Quabbin Community Coalition to address the need for family planning services in rural communities of western Massachusetts 	I

TABLE SPM-1B
Programs/Activities Needing Review/Revision for SPM #1

Programs/Activities	Pyramid
<p>Family Planning Program</p> <ul style="list-style-type: none"> • Evaluated the current program performance measures and made recommendations for improvement. • Alan Guttmacher Institute data on women in need has been updated to 1995 only and is based on 1990 census. New data will not be available until 2000 census is complete. 	I
<p>Combined Primary Care Program</p> <ul style="list-style-type: none"> • Improved tracking and follow-up of referrals to family planning programs are needed to help ensure that women actually receive needed services. DPH program staff will be working closely with Family Planning staff to explore strategies to improve collaboration between the programs, including referral follow-up and tracking. 	I, E

SPM #2 – The degree to which children with special health care needs and their families have appropriate care plans in place.

Status of Annual Performance Indicator: 11

Indicator: () is new (X) has improved () has stayed the same () has not improved

Objective Met/Exceeded: () Yes (X) No

Source of Data: State CSHCN Programs

State Priority Need Being Addressed: Related to NPM #03: The percent of CSHCN with a medical home

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Extended vacancies in leadership positions in several key programs are the primary cause of delays in achieving progress on state performance measure #2.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table SPM-2A. Programs to be reviewed or revised are in Table SPM-2B.

TABLE SPM-2A

Programs/Activities Contributing to Success of SPM #2

Programs/Activities	Pyramid
Early Intervention • All enrolled children and families are required to have an IFSP within 45 days of enrollment	E
Mass Genetics Program • Began development of quality indicators for family-centered genetics health care services	I
Growth and Nutrition Program • All children receive health care management relating to nutrition improvement for FTT. Linkages are made to a medical home and social service referrals made as needed.	D, E
Family and Community Support	E
MassCARE	E
Enhanced School Health Services • Contracts require that any child requiring health services during the school day must have an individualized health care plan. All children receiving medications during the school day must have a medication administration plan (per the state regulations). • 4,227 new individualized health care plans and 11,030 ongoing IHCPs per month • 5774 daily medication prescriptions and 7,002 PRN scripts, all requiring a med. administration plan	E, D

TABLE SPM-2B**Programs/Activities Needing Review/Revision for SPM #2**

Programs/Activities	Pyramid
<p>Family And Community Support</p> <ul style="list-style-type: none"> The Director of Family and Community Support position, which includes responsibility for DPH case management services for CSHCN, was left vacant approximately two years ago. For over a year, another manager filled the position on an acting basis. She ultimately decided not to be a candidate for the position on a permanent basis, however. During her tenure, she did not make any major changes in the program, feeling that these should be the prerogative of the new director. At present, major changes in the program are envisioned, which should enhance our ability to achieve this objective when a new director starts on 7/1. FCS is too disconnected from the health care system to achieve success on this measure; it did create a plan, but only for the program itself. <i>(see related discussion in Table NPM-1D)</i> 	I
<p>MassCARE</p> <ul style="list-style-type: none"> The MassCARE director position was just filled after being vacant for nine months. Under the previous director progress was made in this direction, although one important substantive issue emerged as an obstacle. Vendors, who work very collaboratively with program staff on the implementation of this program, felt strongly that among their clients, the process of signing a form is closely associated with informed consent. They note that the AIDS world is very focused on research and that AIDS/HIV patients are protected by unique confidentiality laws. As a result, their patients have a lot of experience giving (or withholding) consent either in relation to clinical trials, or in relation to release of records to a referral site or for some other purpose. Vendors did not oppose the idea of a mutually developed care plan, but resisted the requirement that it be signed by the client, feeling that this would imply that it has the kind of legal weight associated with consent. We were moving in the direction of modifying the requirement when the previous director left. The discussion will now be revived under the new director. 	I, E
<p>Growth and Nutrition</p> <ul style="list-style-type: none"> Care plans have been included as a performance measure in contracts for Growth and Nutrition programs. This is the first year these contracts have included performance measures, however, and emphasis has not been placed on enforcement. In the coming year, we will enforce this requirement. 	D, I

SPM #3 – Percent of children and youth enrolled in Medicaid, CMSP, or Title XXI who receive any preventive (well-child) services annually.

Status of Annual Performance Indicator: 46.7%

Indicator: () is new () has improved () has stayed the same () has not improved
 Objective Met/Exceeded: () Yes () No

Source of Data: Division of Medical Assistance, CMSP

See text and related notes in ERP for this performance measure detail sheet.

State Priority Needs Being Addressed:

- #1: Implementation of Massachusetts Bright Futures Campaign to increase age-appropriate utilization rates of preventive primary care for all children and adolescents. (*dropped as of July 2000*)
- #9: Monitoring the impact of health insurance reform on access and quality of care for children and youth and on MCH service programs. (*modified July 2000*)

Population(s) served: () Pregnant Women, Mothers and Infants () Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table SPM-3A. Programs to be reviewed or revised are in Table SPM-3B.

TABLE SPM-3A

Programs/Activities Contributing to Success of SPM #3

Programs/Activities	Pyramid
<i>See Table NPM-13A for additional discussion of programs / activities listed here</i>	
CMSP	E
Combined Primary Care Program: Pediatric and Adolescent Components	D, E
School Based Health Centers	D, E
School Health Services – Enhanced School Health	E
WIC	
<ul style="list-style-type: none"> • Medical Advisory Board provides contacts and advice on how to increase enrollment in 3rd party programs for preventive services 	E, I
MCH Home Visiting Programs	E
<ul style="list-style-type: none"> • <input type="checkbox"/> Home visitors educate enrolled families about the importance of primary preventive health care, and assist parents with any barriers to well-child care for their children, including providing transportation 	
FOR Families	E
<ul style="list-style-type: none"> • Home visitors assist families with barriers to access to health care and services • Referrals made to primary and specialty health care providers as needed 	
Early Intervention	E
<ul style="list-style-type: none"> • Families of enrolled children are assisted with barriers to access to health care and services • Referrals made to primary and specialty health care providers as needed 	

Programs/Activities	Pyramid
<p>Growing Up Healthy/Creciendo Sano” (child health diary <i>See NPM 13</i></p> <ul style="list-style-type: none"> • <input type="checkbox"/> Bilingual posters were planned for use in pediatric practices, community health centers, and community based programs to encourage partnerships between parents and pediatric health care providers and keep regularly scheduled well-child visits • <input type="checkbox"/> Spanish and English public awareness campaigns targeting parents of young children, were planned for newspaper, radio, and television, to communicate the importance of child preventive health care and encouraging parents to see their children’s health care providers as key resources and partners for assuring each child’s health development. 	<p>P, I</p>
<p>State Office of Rural Health</p> <ul style="list-style-type: none"> • Collaborated with the DMA, BFCH Health Access Unit, and the DHCFP on the development of programs to fund innovative projects for community-based organizations. • Provided technical assistance and support to the Mass AHEC on their successful Federal Rural Health Outreach application for funding to demonstrate a rural model for outreach and enrollment for the uninsured families in a publicly funded health plan and moving beyond enrollment into strategies for improving the utilization of preventive health services among these families. 	<p>I</p>

SPM #4 – Percent of Medicaid-enrolled children and youth who receive preventive dental services annually.

Status of Annual Performance Indicator: 26.3%

Indicator: () is new () has improved () has stayed the same (**X**) has not improved
Objective Met/Exceeded: () Yes (**X**) No

Source of Data: Division of Medical Assistance

State Priority Need Being Addressed:

#4: Improvements in oral health for children and youth, particularly those depending on publicly funded oral health coverage.

Population(s) served: () Pregnant Women, Mothers and Infants (**X**) Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table SPM-4A. Programs to be reviewed or revised are in Table SPM-4B.

TABLE SPM-4A**Programs/Activities Contributing to Success of SPM #4**

Programs/Activities	Pyramid
The Office of Oral Health <ul style="list-style-type: none"> • Worked with the Division of Medical Assistance(DMA)/Masshealth to teach, provide education and give assistance to ESPDT providers and recipients • Provided technical assistance to DMA/MassHealth for a RFR to develop a statewide dental infrastructure • Provided technical assistance to DMA/MassHealth to revise the administration policy and fee schedule for MassHealth providers. • Provided technical assistance to CMSP for the development and implementation of a dental plan for children to age 18. • Administered a school-based Fluoride Mouthrinse Program for children living in non-fluoridated communities 	P, I
School Based Health Centers <ul style="list-style-type: none"> • <input type="checkbox"/> In FY 99, a total of 1671 preventive dental visits were provided to children in the MassHealth program 	D
School Health Services – Enhanced School Health <ul style="list-style-type: none"> • <input type="checkbox"/> Required to begin to implement programs for dental screening. • <input type="checkbox"/> During the 1999 school year, 58.3% of the Enhanced programs provided dental screening to 22,304 children. 	P, D, E
Growing Up Healthy/Creciendo Sano” (child health diary) <ul style="list-style-type: none"> • <input type="checkbox"/> Three pages address preventive oral health for children from birth through age 6 and provide information to assist parents in finding dental care services accepting Medicaid 	P, I
WIC <ul style="list-style-type: none"> • <input type="checkbox"/> Colorful child toothbrushes and dental health education materials are provided to all enrolled children. • <input type="checkbox"/> Dental health education is provided through special group education. 	E
State Office of Rural Health <ul style="list-style-type: none"> • Worked with the Office of Oral Health to address the critical lack of dental services in rural areas • Updated rural communities on the Bureau’s oral health resources and the collaborative work being done with the Division of Medical Assistance • Assisted with providing technical assistance to communities in rural areas targeted for state funds to support the opening of new dental clinics along with community outreach and education on oral health. • Developed and facilitated a session on oral health services in rural areas at the New England Rural Health Roundtable Annual Conference. 	I

TABLE SPM-4B**Programs/Activities Needing Review/Revision for SPM #4**

Programs/Activities	Pyramid
Factors affecting performance measure that are not specific to programs <ul style="list-style-type: none"> • A shortage of dentists willing to participate in the MassHealth (State Medicaid) Program is the primary reason for the low percentage of Medicaid-eligible children receiving dental services. Inadequate reimbursement rates continue to impact the program resulting in the diminishing number of participating providers. • Other issues identified as hindering the progress include transportation and lack of understanding of the importance of oral health care. 	

SPM #5 – The percent of women who report not smoking during their current pregnancy.

Status of Annual Performance Indicator: 88.2%

Indicator: () is new (**X**) has improved () has stayed the same () has not improved
 Objective Met/Exceeded: (**X**) Yes () No

Source of Data: MDPH Vital Records

State Priority Need Being Addressed: #2: Improvement of Pregnancy Outcomes

Population(s) served: (**X**) Pregnant Women, Mothers and Infants () Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table SPM-5A. Programs to be reviewed or revised are in Table SPM-5B.

TABLE SPM-5A
Programs/Activities Contributing to Success of SPM #5

Programs/Activities	Pyramid
<p>Combined Primary Care Programs – Perinatal</p> <ul style="list-style-type: none"> • This is a contract performance measure for the programs. • Quit Together Perinatal Smoking Cessation grant is offered at 10 selected WIC programs. • 80.6% of women who received prenatal care at a DPH-funded primary care site(CY98) reported not smoking during pregnancy. This is up from 75.4% in 1997. This percentage is lower than the state rate; however two factors may account for this: 1) there is a greater percentage of women from acknowledged high risk populations enrolled in DPH funded primary care sites; and 2) this self-reported question is asked at 2 different times during pregnancy in the CPCP, as opposed to a single point in time for the birth certificate, which may result in more accurate data for this item. 	E
<p>MCH Home Visiting Programs</p> <ul style="list-style-type: none"> • All home visiting programs use an assessment tool which includes information about maternal smoking and family members who smoke • Home visitors provide education on smoking and environmental smoke risks and referrals to smoking cessation programs for women and family members, as indicated. • There is a performance measure on educating women who are pregnant about smoking and other substance use. • Some of the programs are located in agencies that also have DPH smoking cessation contracts. This often increases the attention given this issue during home visiting. 	E
<p>WIC</p> <ul style="list-style-type: none"> • All women enrolled in WIC and parents/guardians of children on WIC who smoke are referred to smoking cessation programs. • Six local WIC programs (3 experimental; 3 controls) continued to participate in a study with the University of Massachusetts Medical Center to develop a strategy to ‘institutionalize’ smoking cessation assessment, readiness to quit, and referral to cessation programs with all providers involved in prenatal care in community health centers. • 67.6% of women enrolled in WIC who delivered in 1998 reported not smoking during their pregnancy 	E

TABLE SPM-5B

Programs/Activities Needing Review/Revision for SPM #5

Programs/Activities	Pyramid
MCH Home Visiting <ul style="list-style-type: none"> Smoking was not fully addressed during this program start-up period. The attempt to standardize an assessment tool for all programs was not completed 	E
WIC <ul style="list-style-type: none"> Continued higher smoking rates among women in some high risk populations 	E

SPM #6 – The rate (per 100,000) of chlamydia cases among females aged 15-19.

Status of Annual Performance Indicator: 1268.7 / 100,000

Indicator: () is new () has improved () has stayed the same (**X**) has not improved
Objective Met/Exceeded: () Yes (**X**) No

Source of Data: State STD Program Data

State Priority Need Being Addressed: #3: Reductions in adolescent risk factors and risk-taking behaviors

Population(s) served: (**X**) Pregnant Women, Mothers and Infants (**X**) Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table SPM-6A. Programs to be reviewed or revised are in Table SPM-6B.

TABLE SPM-6A

Programs/Activities Contributing to Success of SPM #6

Programs/Activities	Pyramid
Family Planning <ul style="list-style-type: none"> Program monitoring, including medical record reviews, of 14 family planning agencies to ensure compliance with specific STD program standards and Department requirements. Ongoing participation of 5 family planning agencies with CDC Infertility Project (Chlamydia Project) which provides funding for universal Chlamydia screening. Ongoing participation on MDPH’s STD Women’s Advisory Committee. Completion of HIV risk survey - identified STD risks of women attending family planning clinics. 	D, I
School-Based Health Centers <ul style="list-style-type: none"> Provide ongoing health education, counseling/support and STD prevention services during student visits to the SBHC. In addition to providing anticipatory guidance, clinical staff assesses and counsels students at risk for STDs. Each high school site has a performance measure that 1) requires that at least 85% of registered users be assessed for sexuality risk factors and 2) requires that 100% of the students determined to be a risk for STD be counseled on means to avoid STDs. As clinically indicated, clinicians screen female students for chlamydia; SBHCs screened 498 students for chlamydia, among whom, 44 reported cases were confirmed. 	D, E

Programs/Activities	Pyramid
Teen Pregnancy Prevention Challenge Fund <i>See also activities in Table NPM-6A</i> <ul style="list-style-type: none"> 111 on-going primary prevention activities specifically on STDs, served 2,341 youth participants; 444 one-time prevention activities focused on STDs served 2,012 participants, including youth, parents and other community members 	P, E, I
Abstinence Education Campaign <i>See activities in Table NPM-6A</i>	I, P
MCH Home Visiting Program <ul style="list-style-type: none"> Home visitors provide education to teen mothers on STD prevention, and make referrals to family planning and primary care providers 	E

TABLE SPM-6B

Programs/Activities Needing Review/Revision for SPM #6

Programs/Activities	Pyramid
Family Planning <ul style="list-style-type: none"> CDC funding for Chlamydia Project is only for selected agencies and excludes males 	D, E
Teen Pregnancy Prevention Challenge Fund <ul style="list-style-type: none"> Increase contractors' capacity re: targeted outreach efforts 	E, I

SPM #7 – The degree to which the State assures that childcare providers have access to qualified childcare health consultants.

Status of Annual Performance Indicator: 3

Indicator: () is new (X) has improved () has stayed the same () has not improved

Objective Met/Exceeded: () Yes (X) No

Source of Data: MaxCare Program Data

State Priority Need Being Addressed:

#5: Assurance of improvements in health and safety of children in all forms of child care

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table SPM-7A. Programs to be reviewed or revised are in Table SPM-7B.

TABLE SPM-7A

Programs/Activities Contributing to Success of SPM #7

Programs/Activities	Pyramid
Max Care: Maximizing the Health and Safety of Children in Out-of-Home Care (state Healthy Child Care America project) <ul style="list-style-type: none"> Supported the Head Start regional health advisor in attending the National Training Institute. Met with the state child care agencies and leaders of the professional association of family child care systems to begin drafting joint standards. Provided materials and TA to agencies in Boston, Springfield, and Lawrence to develop community-based models of child care health consultation to family child care providers who may or may not be affiliated with a system. These newly formed linkages have resulted in relationships between individual 	I

Programs/Activities	Pyramid
<p>child care providers and nurses, pediatricians, and nurse practitioners.</p> <ul style="list-style-type: none"> • Strategies for assisting child care providers included training by experts within DPH and specialty fields (ie; SIDS prevention, asthma management) on a wide range of health and safety topics; a toll-free health line for obtaining technical assistance; and materials development and dissemination. Legal unlicensed in-home and relative care providers (as mandated by TANF) received smoke detectors, no choke tubes, and first aid kits as a result of funding identified by the state child care agency and technical resources from DPH. • Because of regulations promulgated in FY97, this fiscal year saw all 2300 child care centers make improvements to their playgrounds. Max Care provided technical assistance and training to providers and licensers to ensure appropriate compliance. Playground injuries are related to childhood death and disability and are the cause of more than half of all injuries in child care programs. • Parent awareness approaches to reduce the risk of skin cancers from childhood sun exposure dispersed through the child care resource and referral agencies and a trainer of trainers curriculum to help child care providers be better health educators for parents • Regulations, standards and policies reviewed included those on quality and staffing, quality improvement project grants, new regulations requiring varicella vaccinations, emergency planning and preparedness, medication administration, water safety and pesticide exposure. 	

TABLE SPM-7B

Programs/Activities Needing Review/Revision for SPM #7

Programs/Activities	Pyramid
<p>MaxCare</p> <ul style="list-style-type: none"> • Limited funding, multiple priorities and a reorganization of the child care system in Massachusetts have created an atmosphere where change in child care health consultation models is best implemented on a community based level. Although this has assisted in building strong local relationships, it slows the progress of creating a statewide infrastructure. • Discussions involving the state child care agency have not resulted in new funding, contract standards, or regulations. 	<p>I</p>

SPM #8 – The degree to which the State assures nutrition screening and assessment, nutrition services (either directly or through referral), and nutrition counseling and education for pregnant women, children and adolescents.

Status of Annual Performance Indicator: 21

Indicator: () is new (**X**) has improved () has stayed the same () has not improved

Objective Met/Exceeded: (**X**) Yes () No

Source of Data: Multiple BFCH programs data and assessments

State Priority Need Being Addressed: #1: Improvements in pregnancy outcomes
#2 Reductions in adolescent risk taking behaviors

Population(s) served: (**X**) Pregnant Women, Mothers and Infants (**X**) Children () CSHCN

Although the state did meet its objective on this measure, the measure has been refined for FY2001, to more accurately capture the elements of a *systems* approach, and to ensure that the Bureau maintains a mechanism for a systematic, on-going review of nutrition-related health issues and responsive program development.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table SPM-8A. Programs to be reviewed or revised are in Table SPM-8B.

TABLE SPM-8A
Programs/Activities Contributing to Success of SPM #8

Programs/Activities	Pyramid
<p>WIC</p> <ul style="list-style-type: none"> • Nutrition assessment, counseling and education at certification for program services. Nutrition education is provided both individually, addressing specific nutrition issues, and in interactive, hands-on group sessions, addressing more general nutrition topics. • Provided nutrition assessment, counseling and education to 36,256 pregnant women, 58,808 infants, 86,150 children under 5, and 21,847 postpartum and breastfeeding women. • Collects, analyzes and reports data and trends for PNSS and PedNSS on children and women enrolled in WIC and Primary Care • WIC nutritionists work closely with Primary care and Bureau-wide projects, including special nutrition issues, such as obesity, and joint contracts. • Develops and provides nutrition education materials to the Combined Primary Care Program • Collects and reports information on physical activity and food security for enrolled women and kids • Develops and provides in-service education for MCH and WIC staff • Administers the WIC Advisory Board and the WIC Medical Advisory Board, that provide input and community liaison in nutrition and nutrition services issues. • Provision and quality of nutrition services are a contract performance measure. 	E
<p>Family Planning</p> <ul style="list-style-type: none"> • Site visits to assess compliance with program standards, including specific standards on nutrition. • Ongoing distribution of folic acid informational materials 	E, I
<p>Growth and Nutrition</p> <ul style="list-style-type: none"> • Provide intense nutrition assessment and management with referrals for other support services 	D
<p>Early Intervention</p> <ul style="list-style-type: none"> • EI Programs have nutrition screening to identify children at risk and refer for farther nutrition assessments and counseling with nutritionist in the community. 	D, E
<p>MCH Home Visiting</p> <ul style="list-style-type: none"> • DPH staff presented information on the home visitation programs at 2 statewide WIC meetings. • Training for all home visitors and supervisors includes nutrition during pregnancy. • Nutritional screening is conducted with all enrolled families, and referrals are made to WIC and/or other nutritional counseling and resources as needed. 	E, I

Programs/Activities	Pyramid
<p>Combined Primary Care Program</p> <ul style="list-style-type: none"> • BFCH specifically fund nutritional services at all contracted CPCP sites with specific parameters on nutrition including 1) screening and assessment coordination with WIC; and 2) referral and assurance of WIC participation developed as part of RFP amendments and site monitoring system. • Standards for nutrition screening and assessments, provider qualifications, and referrals and follow-up were adopted. • DPH Primary Care and WIC staff developed contract amendment language to have programs develop written protocols on WIC / MCH coordination, and amend forms so data could be shared between programs as part of PNSS and PedNSS program data linkage project. • Primary Care Nutritionist was Co-PI on the PNSS Data Quality Expansion (DQE) grant funded by CDC to study the quality of PNSS and PedNSS data and to pilot test food security and physical activity in children served in the WIC and Primary Care programs. • Collaborated with American Dietetic Association to integrate nutrition services for CSHCN into primary care settings. • Update the Nutrition Resource Directory for Children with Special Health Care Needs. • Program staff participated in WIC Advisory Board's efforts to integrate latest policies and procedures on screening and assessment • Participated in the American Dietetic Association grant to plan regional training raise awareness of special needs nutrition and integration with primary care nutrition networks through NE. • RFP committee to integrate nutrition and physical activity into the activities of the CHNA. • Conducted multiple in-service trainings for CHC nutritionists and Primary Care staff • Helped organize videoconference on "Pediatric Epidemic: Managing Obesity". 	<p>D, E, I</p>
<p>School-Based Health Centers</p> <ul style="list-style-type: none"> • Elementary school sites have a performance measure that 1) requires that at least 85% of registered users be assessed for nutrition risk factors and 2) requires that 100% of the students determined to be a risk nutrition problems (overweight or underweight) be counseled. • In FY99 a nutritional assessment was included in a total of 6132 SBHC visits. • As part of the data collection system, children with BMI outside the normal range are flagged in the system and the SBHC is notified. 	<p>D, E</p>
<p>Enhanced School Health Service Programs/School Health</p> <ul style="list-style-type: none"> • Required to begin to develop programs for nutritional screening for high-risk children. • School Health Institute, in collaboration with the Mass. School Nutrition Taskforce, presented program on nutrition initiatives in the schools. Forty school health personnel attended the program. • 58.3% of the programs reported screening 7,023 students. 	<p>E, I</p>
<p>Healthy Start</p> <ul style="list-style-type: none"> • Distribute educational literature to enrolled women on prenatal health, including nutrition 	<p>E</p>
<p>Growing Up Healthy/Creciendo Sano" (child health diary)</p> <ul style="list-style-type: none"> • More than 20 pages detail nutrition information for women and children. All materials are consistent with those used by the WIC program, & WIC nutrition counselors utilize the diary in sessions with participants prenatally, postpartum and through age 5. 	<p>P, I</p>
<p>FIRSTLink</p> <ul style="list-style-type: none"> • Home visitors screen for nutritional risk and offer information and referrals for nutritional services and food security, including WIC, food stamps, and other local food resources 	<p>P, E</p>

<p>Massachusetts Osteoporosis Awareness Program</p> <ul style="list-style-type: none"> • \$437,000 awarded to program partners for comprehensive osteoporosis awareness and prevention education projects. • Advisory Committee members, pediatricians and pediatric nurse practitioners were surveyed to identify key messages for the development of a pediatric reference card, mailed to 8,000 pediatricians and pediatric nurse practitioners to foster counseling for the calcium intake and physical activity. • The Osteoporosis Resource Directory was updated and expanded to include resources for professionals working with children and adolescents. • A special supplement to the Osteoporosis Education Guide was developed for use by professionals targeting youth. • Increase in Speakers Bureau diversity to reach underserved populations. • Presented at a multiple professional trainings, including the Healthy People 2000 conference in Plymouth, the Ounce of Prevention Conference, and The Men of Color screening programs. • Professional materials updated to reflect new guidelines, prevention and treatment strategies • Development and distribution of new and existing materials for physicians 	<p>P, I</p>
<p>This is Your Life</p> <ul style="list-style-type: none"> • Participated on the Advisory Board for the NIH Osteoporosis and Related Bone Disorders Resource Center to provide input on program development of a national campaign targeting Latina teen girls • Provided 8 underserved schools with "This is Your Life", a health promotion theatrical performance. Over 20 additional schools purchased the program. National media coverage was received on eating disorders and their relationship to osteoporosis later in life. • A training was held for speakers bureau consultants on a new curriculum targeting youth. Twenty eight youth educators from across the state participated 	<p>I, E</p>
<p>Healthy Bones</p> <ul style="list-style-type: none"> • Provided the Healthy Bones Program to 25 underserved schools in the Commonwealth (2,500 children reached). Over 25 additional schools obtained the program without support. • Program staff and Advisory Committee members provided input and support to Tufts University on the development of a successful NIH grant application to target 1st - 3rd graders in 65 after school programs across the state with behavior change strategies promoting nutrition and physical activity 	<p>P, E</p>

TABLE SPM-8B

Programs/Activities Needing Review/Revision for SPM #8

Programs/Activities	Pyramid
<p>WIC</p> <ul style="list-style-type: none"> • The prioritization and use of nutrition information in people's daily lives remains a challenge 	<p>P</p>
<p>MCH Home Visiting</p> <ul style="list-style-type: none"> • Improve education for program staff on nutritional needs and issues for infants and toddlers 	<p>P</p>

SPM #9 – The degree to which there is a statewide system for early identification, referral, appropriate services, and care coordination for all newborns at risk.

Status of Annual Performance Indicator: 22

Indicator: () is new (**X**) has improved () has stayed the same () has not improved

Objective Met/Exceeded: (**X**) Yes () No

Source of Data: Multiple program data and assessments

State Priority Need Being Addressed:

#8: Development of an integrated system of early risk identification, follow-up, referral, services, and family involvement.

Population(s) served: (X) Pregnant Women, Mothers and Infants () Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table SPM-9A. Programs to be reviewed or revised are in Table SPM9-B.

TABLE SPM-9A
Programs/Activities Contributing to Success of SPM #9

Programs/Activities	Pyramid
<p>Massachusetts FIRSTLink</p> <ul style="list-style-type: none"> Expanded to two new communities, Chelsea and Boston, for a total of seven communities, and increased participating hospitals from 6 to 11. This increased the number of families that could potentially be served by 71% from 6,624 at the end of FY98 to 11,323 at the end of FY99. Released a new version of the FIRSTLink Outcome Tracking software to improve the accuracy and consistency of the outcome information returned by home visit providers Refined the referral protocols, to ensure that newborns with infant clinical risk characteristics were connected to a local Early Intervention for screening and assessment and that infants of first time teen mothers were referred to the Healthy Families Program. Held statewide meetings and provided on-site technical assistance to community providers and hospitals. 	<p>P, I</p>
<p>Early Intervention</p> <ul style="list-style-type: none"> Local EI staff participated in all Community Resource Teams to ensure appropriate referral and linkage to EI services for at-risk newborns 	<p>E, D, I</p>
<p>MCH Home Visiting Programs</p> <ul style="list-style-type: none"> Increased funding in FY99 allowed expansion of the Healthy Families program to serve more first-time teen parents 	<p>E, I</p>
<p>New England Regional Newborn Screening Program <i>See NPM # 4</i></p>	<p>P</p>
<p>Massachusetts Newborn Hearing Screening Program <i>See NPM #10</i></p>	<p>P</p>
<p>WIC</p> <ul style="list-style-type: none"> Staff coordinates services with programs serving at-risk newborns. Service coordination is a core standard for site evaluation. 	<p>E, I</p>

TABLE SPM-9B
Programs/Activities Needing Review/Revision for SPM #9

Programs/Activities	Pyramid
<p>FIRSTLink</p> <ul style="list-style-type: none"> Improve factors affecting the hospital consent process and rate Improve areas of programs identified in parent survey 	<p>P</p>
<p>MCH Home Visiting Program</p> <ul style="list-style-type: none"> Expansion of FIRSTSteps was not possible at this time due to level funding 	<p>I</p>

Programs/Activities	Pyramid
Data systems <ul style="list-style-type: none"> The data systems of the key programs are not currently linked to allow optimal tracking of identified at-risk children across programs. The FIRSTLink system only tracks the types of referrals made for a family, not the outcome of referrals. The ultimate goal of linking the FIRSTLink data system with the data systems of other related MDPH programs to obtain that information has been hindered by systems and confidentiality issues. This makes it difficult to match the family's referred through FIRSTLink a specific program's client list to see if a family referred to a program was actually enrolled and served. 	I

SPM #10 – The (a) selection or development and (b) utilization of reliable and easily measurable indicator(s) to track the management of childhood asthma.

Status of Annual Performance Indicator: N/A

Indicator: () is new () has improved () has stayed the same (X) has not improved
 Objective Met/Exceeded: () Yes (X) No

Source of Data: Asthma Workgroup

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

This measure has been dropped, and focus on asthma is included in a new priority need. See Needs Assessment Section 3.2.1/

Programs to be reviewed or revised are in Table SPM-10B.

TABLE SPM-10B
Programs/Activities Needing Review/Revision for SPM #10

Programs/Activities	Pyramid
Asthma Workgroup <ul style="list-style-type: none"> This DPH-wide group has been meeting since 1997 to share information on current asthma-related activities both within and outside DPH, to provide a basis for coherent DPH participation in coalitions addressing asthma, and to promote further efforts related to asthma prevention and care. The long term plan was to identify gaps in systems of care statewide, and develop interventions as needed. There has been active participation of the Bureau (represented by early childhood staff within MCFH, staff of EI and division director from DSHN, and staff of School Health as well as Title V Director), and of the Bureaus of Health Research, Statistics and Evaluation, Environmental Health and Communicable Disease. At this point, Department has concluded that there is need for enhanced capacity to address asthma statewide, and is hiring an Asthma Coordinator beginning 7/00. Region 1 Public Health-Managed Care <ul style="list-style-type: none"> Participated in a collaborative effort to address asthma through development of a statement on basic insurance benefits required for adequate care of children with asthma; a protocol to promote best practices in PCP offices; and a strategy for school liaison and communication. 	I
WIC <ul style="list-style-type: none"> Revised nutrition coding to identify and track incidence of asthma in children 	I

2.5 Progress on Outcome Measures

Please refer to ERP Form 12 in Supporting Document 5.8.

Outcome Measure #1 – The infant mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 5.1

Indicator Has: Improved Not Improved
Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Outcome Measure #2 – The ratio of black infant mortality rate to white infant mortality rate.

Status of Annual Outcome Indicator: 1.9

Indicator Has: Improved Not Improved
Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Outcome Measure #3 – The neonatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 3.9

Indicator Has: Improved Not Improved
Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Outcome Measure #4 – The postneonatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 1.2

Indicator Has: Improved Not Improved
Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Outcome Measure #5 – The perinatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 9.1

Indicator Has: Improved Not Improved
Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Outcome Measure #6 – The child death rate per 100,000 children aged 1-14.

Status of Annual Outcome Indicator: 11.2

Indicator Has: Improved Not Improved
Objective Met/Exceeded: Yes No

Source of Data: MDPH Vital Records

Massachusetts Priority Needs

The following section contains descriptions of additional programs and activities that contributed to the selected State Priority Needs in FY99. **These priorities are limited to those not already addressed in the national and/or state performance measures.**

Priority Need 1

Implementation of Massachusetts Bright Futures Campaign to increase age-appropriate utilization rates of preventive primary care for all children and adolescents.

Programs/Activities	Pyramid
Collaborated with DMA, the United Way “Success By Six” campaign, and others in implementing the Massachusetts Bright Futures Campaign , a major initiative to strengthen system capacity, improve health care delivery, and increase service integration at both the state and local levels to increase age-appropriate utilization rates of preventive primary care for all Massachusetts children and adolescents. A key strategy is the production, distribution, and promotion of 85,000 copies of <i>Growing Up Healthy/Creciendo Sano</i> to the parents of children ages 0 - 6 (see SPM #3). Training and orientation on Bright Futures and the child health diary to ensure both outreach and reinforcement of diary use was implemented statewide for birthing hospitals, health care providers, home visiting and WIC programs, and other community-based family support service providers.	I, P

Priority Need 3

Reductions in adolescent risk factors and risk-taking behaviors

TABLE PN-3

Programs/Activities	Pyramid
<p>Abstinence Education Campaign</p> <ul style="list-style-type: none"> • Developed an infrastructure for expansion and growth through coordinated efforts with other existing pregnancy prevention initiatives statewide • Built and increased capacity for growth and development through the community advisory board and by enlisting new collaborators working with adolescents and families • Researched statewide programs and agencies working on adolescents health issues • Augmented list of collaborators including community agencies, community centers, faith based organizations, etc. for distribution of education materials • Augmented list of youth serving programs for distributing teen collateral items • Adapted and modified new messages to reflect key research findings such as presenting realistic scenarios and consequences of actions • Developed new survey tools to assess messages contents and effectiveness • Conducted 12 pre and post focus groups comprised of youth, parents, health educators for the development of culturally competent and age appropriate messages as well as assessing effectiveness of messages. 	I, E
<p>Adolescent Nutrition and Health Promotion Activities</p> <ul style="list-style-type: none"> • Numerous presentations, workshops, and lectures on nutrition related issues for adolescents Audiences included Tobacco Program peer leaders and advisors, Massachusetts Prevention Center staff, school nurses, “Protect Teen Health” program directors, school foodservice directors and managers, health educators, dieticians and nutritionists, and adolescents at a residential/day program. 	P
The Healthy Choices program also conducted presentations and workshops on Designing School-Based Nutrition and Physical Activity Programs.	I

Programs/Activities	Pyramid
<p>School Health Services and Enhanced School Health</p> <ul style="list-style-type: none"> • Provide comprehensive health education programs, including tobacco use prevention education and make available cessation programs for students. • Tobacco Prevention and Cessation Efforts: 1905 students and 19 adults participated in tobacco prevention education groups in 19 districts reporting; 393 students and 2 adults participated in tobacco cessation groups in 15 districts reporting; 1864 students and 533 adults received individual tobacco cessation counseling; and 507 students and 136 adults were referred to other tobacco prevention/cessation services in 20 districts reporting. • Classroom Health Education by School Nurses: 275 full-time school nurses in 25 ESHS districts reported a total of 4,479 classroom presentations to students. 	<p>I</p> <p>E, P</p> <p>E, P</p>
<p>Violence Prevention and Intervention: Sexual Assault Prevention and Survivor Services/Batterer Intervention/Teen Dating Violence Intervention Project</p> <p><i>Given the correlation between suicide and being survivor of sexual assault, these activities also contribute to suicide prevention of youth 15-19, i.e. Core Performance Measure #15.</i></p> <p><i>Rape Prevention Education</i></p> <ul style="list-style-type: none"> • 5 sexual assault prevention peer education and mentoring demonstration projects, with focus on adolescent males and cultural/linguistic minority youth, • Rape crisis centers trained youth workers, adolescents, and school personnel on working with adolescents • Statewide conference on child and adolescent sexual assault prevention was attended by over 250 youth workers, peer leaders, rape crisis center staff, and school personnel. Two additional statewide trainings were provided to school personnel via the School Health Institute, in partnership with the DOE Teen Dating Violence Program and DPH School Health Program. YRBS adolescent sexual assault data was completed and presented to rape crisis centers and to the Governor’s Commission on Domestic Violence. <p><i>Intervention with Adolescent Perpetrators of Dating and Domestic Violence</i></p> <ul style="list-style-type: none"> • Development and dissemination of pilot program specifications for programs working with adolescent perpetrators of dating and domestic violence. Funded 9 certified batterer intervention programs to work with youth using these program specifications. Program worked with nearly 50 schools across the state to provide prevention education regarding teen dating violence as well as intervention services to victims identified as survivors. 	<p>E, P</p> <p>I</p>

Priority Need # 8: Development of integrated system of early risk identification, follow-up, referral, services, and family involvement for children ages birth to 3

Priority Need 9:

Monitoring of impact of implementation of health insurance reform on access and quality of care for children and youth and on MCH service programs

TABLE PN-9

Programs/Activities	Pyramid
SSI and Public Benefits Outreach, Training, Technical Assistance and Policy Activities <ul style="list-style-type: none"> • Participate in a Children's Health Access Coalition which monitors SCHIP expansions • Include the SCHIP expansion information regarding the MassHealth program in training materials to notify providers of the changes in Medicaid eligibility for children • Track the expansions/changes in MassHealth and SCHIP & disseminate information on changes (effective 8/24/98) to Bureau, Division and health care provider network 	I, P
State Office of Rural Health With the MDPH Rural Health Workgroup, held 4 Rural Health Forums attended by over a 200 providers, community groups, local officials, and consumers	I

Priority Need 10:

Monitoring of impact of welfare reform on health status and access to services for MCH populations and service programs

TABLE PN-10

Programs/Activities	Pyramid
SSI and Public Benefits Outreach, Training, Technical Assistance and Policy Activities <ul style="list-style-type: none"> • Attended trainings by DTA and MA Law Reform Institute on TAFDC (re: welfare reform and cash benefits; extension of time limits; waivers and exemptions) and distributed materials to MCH staff • Gave updates on the changes in the children's disability criteria for SSI with BFCH staff and health care provider network 	I, P
FOR Families <ul style="list-style-type: none"> • <input type="checkbox"/> Provides on-going assessment outreach and referral for families transitioning off Welfare due to time limits for all families referred from DTA and those failing to recertify for food stamps 	E
Food Stamp Outreach Program <ul style="list-style-type: none"> • Regional programs provided targeted outreach, application assistance and community specific education for families potentially eligible • The statewide Project Bread's Food Source Hotline provided information, prescreened families, and conducted statewide outreach through schools, fuel assistance programs and other sites 	P, E
WIC <ul style="list-style-type: none"> • Provided caseload enrollment data to McCormack Institute for a major report on the impact of welfare reform. 	P

Programs/Activities	Pyramid
Sexual Assault Nurse Examiner Program	D
State Office of Rural Health (SORH) <ul style="list-style-type: none"> • Formed the MDPH Rural Health Workgroup comprised of staff from all Bureaus and key offices in • Provided MCH information, TA, and support to 7 rural community coalitions, 4 rural CHCs and others • Collaborated with other state programs on additional services for rural areas, such as: Breast and Cervical Cancer Program, School Health, Family Planning Program, Children’s Medical Security Plan, Violence Prevention Unit, Primary Care Programs, State Loan Repayment Program, J-1 VISA Program, etc. • Mailed announcements about the Federal Rural Health Outreach and Network Grants to over 1,500 rural colleagues. The SORH responded to over 200 callers wanting additional information about the grants and then provided TA to 5 groups working on applications. • Developed a successful federal application for the Rural Hospital Flexibility Program to develop a rural state plan for the designation of Critical Access Hospitals, provide support and technical assistance for stabilizing rural hospitals, and improve the accessibility and comprehensiveness of rural health networks and EMS services. • Supported the development of a new rural health association for the New England region called, the New England Rural Health RoundTable. The SORH participated actively on the Leadership Steering Committee, Annual Conference Committee, and Policy Committee and ensured the participation of Massachusetts people in all RoundTable activities. • Worked with Blackstone Valley CHNA on a series of community awareness activities and the development of informational resources on violence against women, child abuse, school-age violence prevention, and youth dating violence. 	I

III. REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The Bureau considers needs assessment to be a continuous process. Data are analyzed at a statewide level, to identify major problem areas and for comparative purposes with national indicators such as the Healthy People objectives, and at a variety of sub-area levels to identify significant regional, Community Health Network Area (CHNA), or city/town variations in statewide rates. Data are also analyzed for key population groups, defined by such characteristics as race and ethnicity, newcomer/immigrant status, age, gender, urban vs. non-urban residence, and, increasingly, combinations of these. Data presented and analyzed at these levels are especially useful for planning purposes and determining resource allocation and the need for geographically targeted programs and services. Where fully adequate data are not readily available, the Bureau works closely with a wide array of advisory groups, task forces, coalitions and networks, and other external groups to fill the gaps.

As the Bureau approached this five-year comprehensive needs assessment, internal organizational changes converged to present a unique opportunity to incorporate needs assessment findings into the organizational structure of the Bureau and its programs. In mid-year, FY2000, there was a change in leadership of the Bureau, with the promotion of Sally Fogerty, B.S.N., M.Ed., to the position of Assistant Commissioner of the DPH and director of the Bureau. A comprehensive, long-range strategic planning process began shortly thereafter, and will be completed in FY2001. Its purpose is to develop a plan to position the Bureau to be able to respond better to changing marketplace needs and the expectations of customers and stakeholders. The strategic planning initiative is intended to build on the Bureau's many strengths and its long history of developing innovative programs and initiatives. In defining priorities and long range goals, the strategic planning will help to establish new approaches and expand existing successful ones.

It is a goal of the Bureau that the Title V Needs Assessment and the annual MCH Block Grant Application assume a more prominent and dynamic role in the day-to day operations of our programs and staff. Activities toward this goal have already begun. From the outset, the needs assessment planning and process involved all of the Bureau's Divisions, with active representation from all programs and initiatives at an increased level from previous years.

A Needs Assessment Working Group comprised of BFCH senior staff and selected unit and program managers from key MCH related programs and from the Office of Statistics and Evaluation was convened in the late summer of 1999. This group assumed the responsibility of giving overall direction to the needs assessment process, and reviewing interim findings as they became available. Membership

included staff with expertise in perinatal health, women's health, early childhood, violence prevention and intervention, nutrition and physical activity, school health, adolescent and youth development, injury prevention, children with special health care needs, oral health, rural health, and data and evaluation including Infant and Maternal Mortality Review. The SSDI Project Director and Coordinator staffed and coordinated the group's activities.

The Bureau made a decision not to base our state's needs assessment on a process that utilized a single methodology (e.g., a household survey, focus groups, or secondary data analysis), but to build on existing activities, surveys, and assessments. Massachusetts is fortunate to have a wealth of needs assessment data available on a regular basis and from a wide variety of sources and perspectives. In addition to national studies, with state-specific extrapolations, numerous state level assessments are conducted on a regular basis by state agencies, health and social service advocacy groups, and the many strong academic institutions in Massachusetts. In addition, the significant internal capacity at MDPH for data collection, analysis, and public dissemination is notable, with the BFCH Office of Statistics and Evaluation and the Bureau of Health Statistics, Research, and Evaluation. Smaller local community needs assessments are also frequently conducted across the state, often in response to grant applications and CHNA and municipal activities. This abundance of data was an asset in planning our MCH Five Year State Needs Assessment, but also presented challenges, with the issues of widely varying methodology, focus, and level of comprehensiveness. Therefore, conducting an inventory of datasets and data sources readily available, deciding which data to include and at what level of significance, and then identifying and working to fill the gaps were the initial priorities of the Needs Assessment Workgroup. The group outlined a four step process: 1) identify the factors affecting the health of the MCH priority populations to include in our needs assessment; 2) review the data and the known issues related to the selected factors; 3) develop and implement approaches to fill the data gaps, including significant community and consumer input; and 4) review the major findings and themes that emerged from this review, to determine the Bureau's MCH priority needs for the next five years, including setting targets for performance measures.

Determining the factors to include in the needs assessment

The first activity was a review of each of the Title V National and State Performance Measures, and the Core and Developmental Health Status Indicators. For each measure, the group reviewed the most current data, beginning with that submitted in our FY98 Annual Report and FY00 Plan and updating that data as it became available during the year. A series of questions was explored in relation to each of the measures/indicators, including:

- By what additional levels should the data be analyzed; e.g., race/ethnicity, age, gender, geography, etc.?

- What other questions should we be asking to increase our understanding of these issues?
- What other data do we need, and how can they be obtained?

The workgroup then identified additional factors that affect the health status of the MCH priority populations, and explored indicators that can measure the impact of these factors on individuals and families. In keeping with the Department of Public Health's broad definition of health, these factors included a wide range of social, economic, educational, and environmental conditions. A number of smaller issue-focused sub-committees were formed to compile and review specific topic-related data, performance measures and health status indicators. The subcommittees focused on violence (especially against women and children), nutrition, perinatal and women's health, mental/behavioral health, and data systems and linkages. These smaller working groups developed recommendations that were presented to the larger needs assessment workgroup, and that ultimately led to the changes in the state performance measures and priority needs. Early consensus was also reached on the need to take a broad view of the MCH population. Research and experience are convincing that in order to positively affect reproductive outcomes, attention must be focused on the health of women before they become pregnant. It is also becoming clearer that to impact the health of children, we must include the needs and contributions of fathers, grandparents, and other family members, within the context of the changing structure of American families in general and Massachusetts families in particular. These perspectives, therefore, formed the framework within which the Bureau conducted its needs assessment:

- a broad definition of health
- a focus on women's health, before, during, and between pregnancies
- a focus on the family, in all its variations, as a significant factor in the health of women and children and children with special health care needs.

Review of existing data

This initial data review included intensive and extensive review and analysis of:

- existing and current needs assessments done for specific programs and communities, including WIC, State Needs Assessment Project (SNAP) focusing on substance abuse, Northern Worcester County Needs Assessment, Worcester Healthy Start, and others;
- program, community, and other databases both internal to the Department of Public Health (birth and death data, BRFSS, Managed Care Enhancement Project report for CSHCN, Prenatal Nutrition Surveillance System, etc.) and external to DPH (Medicaid, other state agencies, hospital discharge data national studies such as the Urban Institute, etc.) and other reports;
- focus group evaluation conducted for various BFCH programs, including FOR Families, WIC and FIRSTLink; and

- a comprehensive literature review related to the integration of women’s health and maternal and child health.

(A list of the sources used is available upon request.)

Datasets and highlighted factors and issues were organized by their contribution to direct care, enabling, population based, and infrastructure building services across the three MCH priority populations. This initial review prompted discussion of the influences and factors contributing to the specific health status indicators or performance measures, and a focus on how each of these factors affects Massachusetts residents, what are the trends for each, such as changing demographics in some communities, and emerging issues raised by anecdotal information from community based programs. For example, the literature review and report on integrating women’s health and traditional MCH services was conducted and presented to BFCH Division and Unit Directors by a graduate student intern from the Boston University School of Public Health, and was also presented at the school’s Maternal and Child Health Forum Day. Discussion generated from this study resulted in the addition of a focus on women’s pre-conceptual health to the existing state priority need around improvements in pregnancy outcomes.

Filling the gaps and obtaining community and consumer input

The workgroup identified the need for qualitative data on many of the issues, and strategies for obtaining community and consumer input on the questions were planned and implemented. The Bureau has an extensive list of collaborating partners representing every program area, as well as other MCH interests (see Table 1.5.2). Partnerships are essential and inherent in the contracting of direct services to community based organizations, which is the predominant method of service delivery by the MDPH. The Bureau and the Department also work to establish and maintain collaborations beyond specific program and service delivery areas, including advocacy and relevant trade organizations, such as the Massachusetts Hospital Association, the Massachusetts League of Community Health Centers, the Federation for Children with Special Needs, Health Care for All, Project Bread, and many others. The Bureau consulted with key partners and informants (using written surveys, discussion groups, individual and group interviews) that included:

- the 27 Community Health Networks (CHNAs)
- BFCH staff in 6 regional offices
- WIC statewide community coordinators and nutritionists
- Parents and parent coordinators of Family TIES
- Health Access Networks
- Perinatal Advisory Committee
- FOR Families home visitors

- Rural Health Advisory Committee
- Division of Medical Assistance (the state Medicaid agency)
- Division of Health Care Finance and Policy
- Department of Mental Health
- Department of Education
- Department of Transitional Assistance
- Behavioral Health Partnership
- Boston Public Health Commission Coalition on Prevention

The MCH Needs Assessment was presented and input solicited at a number of gatherings of consumers and relevant stakeholders during the year, including BFCH and MDPH division and program staff meetings, the statewide annual meeting of the Community Health Network area (CHNA) coalitions, advisory committee meetings, a statewide meeting of WIC nutritionists and community coordinators, Regional BFCH staff, and a statewide joint conference of Family TIES, the Federation for Children with Special Needs and Families Organizing for Change (families of children with special health, cognitive, and behavioral needs). These groups include a mix of parents and consumers, BFCH program staff, and community-based providers, with emphasis on those staff and providers who have direct contact with pregnant women, children and teens, children with special health care needs, parents and other family members.

Input from these sources was gained largely through key informant interviews, group interviews and discussion, focus groups, and written surveys. The CHNAs are particularly important collaborators, as they afford access to a broad-based provider network and community-based organizations and individuals from all areas of the state. Major MCH and CSHCN program areas and systems are represented, including primary care, Early Intervention, family planning, home visiting and family support, and others. These coalitions conduct local focused needs assessments and select specific health improvement projects to address collectively at the local and area level. After a planning meeting with the Director of the Office of Healthy Communities, the SSDI coordinator made a poster presentation at the CHNA annual gathering, and distributed the first survey to that group.

The survey was developed to obtain input from a sample of essential collaborating partners and from parents and consumers that could give us a current and dynamic picture of major needs and concerns of the MCH population from various perspectives. This brief survey, which contained open-ended questions, constructed to allow simple tabulation and categorization of the responses, asked the respondent's perception of the three most pressing needs of the MCH priority populations, both at the current time and those anticipated in the near future. Additional questions sought feedback about services,

programs, and/or activities that MDPH could provide to respond to these needs, and other more general ways in which the Bureau could provide support and leadership in this area in the community. The general structure and focus of the survey was the same for all groups, but the specific wording of the questions was modified as the project progressed. This was partly an effort to tailor the questions to the different groups to whom the survey was distributed, and partly a result of the experience gained as we progressed about which questions and wording elicited the most interest and information from the respondents. In addition to the 27 CHNA coalitions, the survey was also distributed to:

- Regional BFCH staff in 6 regional offices, that included Health Access Specialists who answer the Family Resource Line (MCH hotline)
- WIC statewide community coordinators and nutritionists
- Parents of CSHCN and parent coordinators of Family TIES.

Nearly 125 parents of CSHCN returned the surveys, including many in Portuguese and Spanish. We also took advantage of information obtained in other recent surveys and focus groups from parents using or eligible for WIC services and from adolescents. Confidence in the information gained through these varying strategies was increased by the fact that certain themes were clearly repeated over and over, from a variety of perspectives.

As issues were identified through all of the various information-gathering methods, the group sought available quantitative data and current research and practice literature on each particular area. For example, as concerns were raised around access to mental / behavioral health care for children and adolescents, BFCH staff met with the Child and Adolescent Unit of the state Department of Mental Health to clarify what services are available to children and youth, eligibility and access issues, and state system issues. Emergency Medical Services and Hospital Emergency Room reports related to children's mental health service needs were also reviewed. The workgroup considered these state-specific needs in the larger context of the public health role of primary prevention. For example, emerging literature is documenting the impact of postpartum depression on maternal health, on parenting capacity, and as a result, on child health outcomes. This work has led to the development of a new priority need in the area of mental health promotion.

Determining the State's MCH Priorities

For the final phase of the Needs Assessment process, a report of emerging themes was made to the full Workgroup and to all of the Bureau's divisions, programs, and regional offices. A series of meetings with Division, Unit, and Program Directors was held to discuss the findings, and review again the state's current performance measures and priority needs in relation to the Needs Assessment. These meetings led to a consensus on making some substantive changes in the priority needs and the state performance

measures for the next five years. The new priority needs define several new areas in which the Bureau plans to focus attention and resources in the coming years, with the goal of developing some new initiatives and programs, and redefining, modifying and/or integrating others. In particular, the revised priorities and state performance measures include a focus on mental health promotion, violence prevention, integration of perinatal and women's health, service integration for children birth to 3, and improved access to MCH services through increased cultural competency, rural availability of services and public awareness. These priority needs are discussed in more detail in Section 3.2.1.

The smaller subgroups with content expertise then reconvened to set performance targets for future years, in collaboration with specialists in the Bureau of Health Statistics, Research and Evaluation. This approach resulted in targets that were set by data trend analysis, tempered with professional and programmatic experience and judgment.

Strengths and Weaknesses of the Process

The participatory process that the Bureau used for this five year Needs Assessment has been a major strength. The breadth and depth of expert knowledge and practice, and the extensive links to community partners that were represented by the large number of staff in the various workgroups made a significant contribution to the quality of the content and outcomes. The on-site meetings with staff in the regional offices were also a very positive aspect of the process, as these staff have historically felt somewhat disconnected from the central office of the Bureau in Boston and less involved in essential planning activities. As a result, there has also been an increased level of staff investment in shaping the state's MCH priorities, and positive anticipation of the program development activities that are expected to follow. The timing of the needs assessment with the Bureau's strategic planning process was fortuitous, as these critical planning activities could be integrated and complementary.

The high level of direct and indirect parent and consumer input into the needs assessment has been another strength. The response rate for the parent surveys was high, especially from parents of children with special needs from diverse ethnic and cultural groups. There is also significant consumer involvement in the CHNAs. In addition, the BFCH regional staff in many instances are in closer contact with local communities and consumers than are program management staff in the BFCH central office, and were therefore able to offer current insightful information about the needs of the MCH priority populations that are presented daily.

The extensive array of available data and the multi-faceted approach that was used to take advantage of existing activities, surveys, and assessments were other strengths of our needs assessment process. In particular, the use of the Internet-based Massachusetts Community Health Information Profile (MassCHIP) facilitated many of the levels of data analyses that allowed the Workgroup to review

disparities among population groups when looking at health status indicators. MassCHIP is a dynamic, user-friendly information service that provides access to 24 health status, health outcome, program utilization, and demographic data sets with many health and social indicators. However, with the exception of a birth/infant death linked file, MassCHIP is limited to single unlinked databases. The need for improved data linkage was underscored during the needs assessment process. The Bureau has applied to MCHB for a Data Utilization and Enhancement grant to develop the Massachusetts Maternal, Perinatal, and Infant Health Database (MPIHD), which if funded, will enhance the state's MCH information infrastructure by linking key Datasets that will allow the Department to better monitor, assess and disseminate information on the health status of women, children and families. Specifically, it will link Massachusetts case-mix data from hospital discharge records of mothers and newborns to live birth and infant death certificates, and expand this linked database through the addition of fetal and maternal death records and program service records of high risk infants and children enrolled in the Department's Early Intervention programs.

Other areas of data linkage that are currently under discussion and planning include the linking of birth data with Medicaid data and the linkage of child care eligibility screening with WIC. The continued study of data linkages, and the development and strengthening of these systems where appropriate, remain an on-going priority of the Bureau.

In some instances, the lack of essential data, including some gaps in easily retrievable data from some of the Bureau's own programs, presented a challenge to the needs assessment process (e.g., the lack of reliable data on the number of CSHCN served in our primary care programs). Also the lack of standardized definitions and numerator/denominators for certain measures was a limitation. For example, the age groups specified in many of the health status indicators and national performance measures related to Medicaid enrolled children receiving certain health care services are different from the age delineation that Medicaid uses to assess and report many of these same measures. The MDPH and BFCH have initiated a project to develop uniform definitions. The initial focus is on the collection of information related to race and ethnicity. This is being linked with activities of the Minority Health Advisory Committee. Emergency Room data is another area in which the lack of reliable data is a significant weakness that impacts a number of priority need areas, such as monitoring asthma and mental health. Patients are increasingly being kept in the Emergency Room for extended periods of time for observation and treatment, rather than being admitted to the hospital, for a variety of conditions. A complete and reliable assessment of a variety of morbidities is not possible without this data. The Bureau is working with the Bureau of Health Statistics, Research and Evaluation, the Division of Health Care Finance and Policy, and the Massachusetts Hospital Association to survey Emergency Departments and services, and to explore development of a uniform reporting process, similar to that developed for the BFCH WATCH

project. Data related to injuries, violence, and asthma will receive the initial focus, although others are planned, including chronic conditions in which exacerbations and emergency room treatment occur.

The need for the household survey that is in the early planning stage at DPH was reinforced by some of the data gaps, and the small samples on which some interpretations were based. This random telephone survey is expected to obtain better and more timely information about families (including families with CSHCN) on a variety of topics from insurance coverage, use of preventive services, risk behaviors, and unmet needs. Thoughtful planning and the inclusion of questions related to MCH priorities will be essential for this project to contribute in a meaningful way to future MCH needs assessments.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population Health Status

Introduction

The primary focus of this overview of the health status of the Maternal and Child Health populations in Massachusetts will be on those topics and issues that may be different in Massachusetts than in other areas, and on those that have emerged as new or growing concerns. This section summarizes the findings of the Needs Assessment, highlighting important trends, disparities, and data points through the use of graphs and charts. The section is organized by each of the MCH priority population groups, followed by a section on health status concerns that are shared by all of the MCH groups. For efficiency, numerical and tabular data are presented in the following ways:

- Cross-references to the relevant Performance Measure and/or Health Status Indicator tables and Forms where the variables are presented for the state.
- Selected data tables in a Supplemental Document for analyses of these items by age, race/ethnicity, etc. where disparities were found and of concern.
- Selected data tables in the Supplemental Document of additional relevant indicators.

The narrative sections 3.1.2.2 through 3.1.2.5 review the systems issues, organized by levels of the MCH pyramid, that have emerged as part of the needs assessment and on the qualitative information gathered from a wide range of perspectives on what are the most important MCH needs and issues for the next five years.

Pregnant Women, Mothers, and Infants

Massachusetts has achieved overall positive reproductive outcomes, with many of the key indicators and outcomes exceeding the state's objectives and better than the U. S. rates as a whole. At the same time, however, there are some areas in which our generally positive progress has reached a plateau, or in which

poorer outcomes have persisted. While improving overall, there continue to be significant disparities in outcomes and measures for some population groups. There are also some concerning trends, such as the growing number of very low birth weight births and the increasing perinatal mortality rate, that are confronting the state. These trends require further analysis and study to identify more clearly the underlying contributing factors and develop strategies for improvement. The major findings regarding perinatal and infant health status are described in this section. Additional detail and graphic representations of the data referenced here are found in SD 5.3.8.

Birth Characteristics

There were 81,406 births in Massachusetts in 1998, which is the most recent data available. While this represents a 12% decrease since 1990, it is an increase for the second consecutive year, following a steady decline in the earlier part of the decade. The overall birth rate was 55.4 for every 1000 women, compared to the national birth rate of 65.6. For teens 15 to 19 years old, the birth rate was 28.6, significantly lower than the U.S. rate of 51.1. Since 1996, there have been more births to women age 30 and over, than to those under 30, and the fastest growing age-specific birth rates in the 1990s were for women ages 40 and above. In 1998, 75.9% of births were to white, non-Hispanic women, 10.6% were to Hispanic mothers, 6.8% were to Black, non-Hispanics, and 4.6% of births were to Asian women. 18.3% of births were to foreign-born women. The total percentage of multiple births was 4.2% in 1998, a 68% increase since 1989. Among women 35 years and older, the percentage of multiple births nearly doubled during this time. Cesarean section was the method of delivery for 20.9% of Massachusetts resident births, and the rate of vaginal births after Cesarean was 32.7%, up from 21% in 1989. (See Tables 5.3.8-1 and 5.3.8-2 and Figures 5.3.8-1, 5.3.8-2, and 5.3.8-3 in Supporting Document 5.3.8.)

Infant mortality

Five of the six Title V Outcome Measures focus on infant mortality. Massachusetts met or exceeded its objectives in four of these (all except perinatal mortality). The infant mortality rate (5.1) has continued to improve for all racial and ethnic groups in the late 1990s and is significantly below the US average. Infant mortality, and its major component measures - neonatal (3.87) and postneonatal (1.22) mortality – are on target for meeting the Healthy People 2010 objectives, and exceed the 1998 baselines for these objectives. The disparity between black and white infant mortality rates (ratio = 1.9), while improved, is still significant and of major concern. Black, non-Hispanics continue to have the highest IMRs in the state. The perinatal mortality rate (9.1) has not met its objective and has not improved. With closer analysis, it appears that this worsening rate is due primarily to deaths in the first 7 days of life, rather than to fetal deaths, although the latter did experience a very slight increase from 1997 to 1998. This finding is

being reviewed by the Perinatal Advisory Committee. (Please see Figures 5.3.8-4, 5.3.8-5, and 5.3.8-6 in Supporting Document 5.3.8.)

Causes of infant death have not changed significantly, with one dramatic exception. The incidence of Sudden Infant Death has dropped from 83 in 1990 to 22 in 1998. This decline is consistent with trends reported nationally, following the aggressive public education efforts regarding infant sleeping position. A potential confounding factor, however, is that in 1998 the continuation in this dramatic drop-off in reported SIDS deaths in Massachusetts occurred at the same time that there was a change in how these deaths were reported. It is not yet clear if some of the continued decline in deaths attributed to SIDS is related to increases in other causes of infant death (for example, deaths to children birth to 4 that were attributed to suffocation increased from 1 to 10 between 1997 and 1998).

Low Birthweight

As the greatest contributing factor to infant mortality, and to neonatal mortality especially, low birthweight is another area of continued concern to the BFCH. The percentage of births that are low birthweight in Massachusetts appears to be rising, and continues to show significant racial and ethnic disparity. This overall percentage was 6.9% in 1998, which was essentially the same as the previous year, and lower than the national figure. However, LBW has been increasing in the state since 1993, when that percentage was 6.1%. Racial and ethnic disparities persist, with the highest rate of LBW occurring among births to black non-Hispanic women (11.8%). The LBW among Asian infants also increased slightly in 1998. When looking at age distributions, the highest percentage of low birthweight births occurred among women under age 20 and over age 35. Although the overall percentage of infants with very low birth weight (1.3%) met the objective for 1998, the rate has been increasing since 1992. While some of the underlying contributors to the incidence of LBW and VLBW are known (e.g., the sequelae of poverty and poor health status prior to pregnancy), others are not. One reason for the increase in LBW and VLBW in Massachusetts appears to be related to a relatively new cohort of women who are over the age of 30, have private insurance and some college education. Multiple births account for approximately 33% of the low birth weight infants, and there appears to be a correlation with fertility treatment. The potential impact of Artificial Reproductive Technology has only begun to be recognized. Massachusetts is the first state to have more births to women over the age of 30 than to those under 30. The health and social implications of this shift have yet to be fully understood, and will be monitored closely over the next years. (See Tables 5.3.8-1 and 5.3.8-2 and Figure 5.3.8-2, in Supporting Document 5.3.8.)

Additionally, the BFCH is concerned about the regional variations in the percentage of VLBW infants delivered at facilities for high-risk deliveries and neonates (NPM17). While the overall objective has been met for the state as a whole (86.6%), the percentage in the Southeast region of the state is

considerably lower at 65.7%. The reasons for this significant variance are not readily apparent, and will be an area of focus for the state's Perinatal Advisory Committee in the coming year (see Table NPM17D).

Smoking

The percentage of women who report not smoking during pregnancy (88.2%) continues to improve. It remains a BFCH performance measure to maintain and further improve this significant perinatal risk factor.

Prenatal Care

The overall percentage of women beginning prenatal care in the first trimester (84.3%) has met the objective and continues to improve, but racial, ethnic and age disparities remain. While first trimester care increased for both non-Hispanic Black women (72.3%) and Hispanic women (71.5%), the disparities in comparison with white, non-Hispanic women (87.9%). Adequacy of prenatal care utilization also varies among racial and ethnic groups, with Cambodian women having the lowest rate (44.7%), followed by Hispanic women (66.9%) and black, non-Hispanic women (67.9%). This indicator varies considerably among communities, with women in some of the larger urban communities having much lower rates of adequate care than the statewide average of 79.8%. Teens also have much lower rates of adequate prenatal care and early entry to care (see discussion of Teen Births below). 24.7% of women had publicly funded prenatal care (MassHealth or Healthy Start), and these women were less likely to receive adequate prenatal care in all race/ethnicity groups. This continues to remain a major focus of BFCH programs. (See Tables 5.3.8-1 and 5.3.8-2 and Figure 5.3.8-7 in Supporting Document 5.3.8.)

Breastfeeding

The number of mothers who breastfeed their newborns continues to increase, reaching 70.9 overall in 1998. For this indicator, many minority groups exceeded the state average, with 75.2% of Asian mothers and 72.2% of Hispanic mothers breastfeeding at hospital discharge. However, there are ethnic groups with much lower rates of breastfeeding, especially Southeast Asian women (below 50%) and Puerto Rican women (60.7%). The rates of breastfeeding among women enrolled in WIC and the BFCH funded Community Health Centers is lower than the state average, reflecting the high proportion of women at increased perinatal risk served in these programs, including low income women and women from racial and ethnic minorities. The promotion of breastfeeding has been a major focus for WIC over the past few years. There has also been an increasing focus on the rate of teen mothers who breastfeed in the WIC program, home visiting programs, and prenatal programs. In addition, the programs are developing plans

to enhance activities, media efforts, and community initiatives to promote continued breastfeeding after the initial months. (See Table 5.3.8-2 and Figures 5.3.8-8 in Supporting Document 5.3.8.)

Teen Births

The teen birth rate has declined 20.1% between 1990 and 1998. Although the Massachusetts teen birth rate is significantly lower than the national rate (18.6 compared to 51.1 in 1998), the national rate has dropped more steadily in recent years, while the Massachusetts rate has remained relatively constant. There are communities in the state where the teen birth rate is considerably higher (e.g., Holyoke at 131.3), with 5 communities having a rate over 80 (per 1000 women ages 15-19). The age distribution of teen births has not changed much in recent years, with 36.1% occurring to women under age 18. The percentage of births to teens who had at least one prior birth declined in 1998 to 16.5%, with the most visible decrease in the younger age group (ages 12 to 17). 50% of teen births are to white, non-Hispanic women, with the percentage of births to Hispanic teens rising, and births to Black non-Hispanic teens decreasing over the past 5 years. 90.7% of births to teens in Massachusetts are to unmarried women. (See Tables 5.3.8-1 and 5.3.8-2 in Supporting Document 5.3.8.)

Because teens have higher rates of poor pregnancy outcomes, including IMR and LBW, a focus on reducing adolescent risk factors remains a priority for the Bureau (see Priority Needs, Section 3.2.1).

Congenital Anomalies

Information on congenital anomalies is presented later in this section under Children with Special Health Care Needs.

Maternal Mortality

Maternal death, while rare, is a critical health indicator for women giving birth. There has been a dramatic decrease in maternal mortality in Massachusetts during the last half of this century, and the state now has the second lowest maternal mortality rate in the U.S. (3.3 /100,000). The leading causes of maternal death have also shifted from infections, pregnancy-induced hypertension, cardiac disease and hemorrhage to injury (suicide, homicide, and motor vehicle crashes) and pulmonary embolus.

The Maternal Morbidity and Mortality Review Committee has completed a comprehensive medical review of pregnancy associated deaths occurring between 1995 and 1998. Of the 88 pregnancy-associated maternal deaths, 60 were caused by medical conditions and 28 by intentional or unintentional injury, drug overdoses, and motor vehicle crashes. Pregnancy associated death is defined as the death of a woman while pregnant or within one year of termination of pregnancy, irrespective of cause. The first report of the Committee was released in May 2000. This bulletin presents Massachusetts-specific data

related to maternal causes of death and pregnancy-associated mortality ratios, summarizes case review findings and suggests strategies for improving maternal outcomes. Improved and expanded case-finding methods used in this study facilitated the identification of more deaths than previously noted, and demonstrate the importance of expert case review in conjunction with an active maternal mortality surveillance system. Of the 88 pregnancy-associated deaths, 30% teach lessons about preventing future deaths. The next bulletin will report on deaths from social causes (e.g. substance abuse, violence) of pregnancy-associated mortality and will provide more in-depth epidemiological analyses. In addition, the Committee has undertaken a comprehensive review of uterine rupture (UR) which will be utilized to develop a UR surveillance model and as a foundation for the development of a maternal mortality surveillance model. Many of the strategies recommended to prevent future mortality and morbidity stress the importance of a strong public health system to support the overall health of women during the child-bearing years.

Unplanned Pregnancy

Unplanned pregnancy may be related to adverse health outcomes for both mothers and infants. Data on women ages 18 and over from the 1998 Massachusetts Behavioral Risk Factor Surveillance System show unplanned pregnancy was reported at highest rates among younger women (under age 24), Black women, and women with lower levels of income. Unplanned pregnancy is also associated with other known health risks, including partner abuse, inadequate health insurance, medium or high risk for HIV, and smoking. Increasing the percentage of pregnancies that are intended is a Healthy People 2010 objective and has been added as a state performance measure as a result of the needs assessment. (See SPM #11 and Figures 5.3.8-9 and 5.3.8-10 in Supporting Document 5.3.8.)

Pre-conceptual Health

To further reduce mortality and morbidity, the BFCH recognizes the need to continue to support and enhance all current efforts as well as to increase the focus on the health of pregnant women, mothers, fathers, families and communities. While the public health efforts that address the needs of the traditional MCH populations are crucial, they have not been sufficient in themselves to fully ensure healthy families. Clinical epidemiology and qualitative infant mortality reviews reveal that lack of integrated and comprehensive health care for women throughout their reproductive years is a major contributor to poor perinatal outcomes. When women do not receive comprehensive preconceptual care, they may enter pregnancy with unaddressed medical and social risk factors that compromise the health of both infant and mother. Premature births, the largest contributor to low birth weight and infant mortality in the US, are related to conditions best addressed before pregnancy begins.

Key issues that must be addressed by the MCH field to achieve integrated, comprehensive women's health care include: 1) insurance coverage for preconceptional care; and 2) reducing fragmentation of care for women. The Kaiser/Commonwealth 1997 National Survey of Health Insurance showed that almost half (47%) of uninsured women received no routine physical exam. In Massachusetts, 6.5% of white women were unable to see a doctor due to costs in 1997, whereas 16.4 % of Hispanic women (1997) and 10.1 % of black women (1996) were unable to see a doctor due to costs. A more in depth needs assessment will help determine which populations of women of reproductive age have least financial access to preconceptional care.

Even when care is available, fragmentation of the health care system may make access to continuous, comprehensive care difficult. The Boston Infant Mortality Review revealed that 73% of the cases reviewed included histories of fragmentation and discontinuity in the health care of women and infants, including those with high-risk histories. Fragmentation is often related to categorical funding streams that encourage specialized reproductive health services without integration into comprehensive services.

To address these needs, a comprehensive, integrated women's health care system must be developed. A priority will be on identifying and addressing those factors that need to be considered before pregnancy occurs. This will include issues related to fertility treatments, chronic disease, nutrition, smoking, substance use, violence, and infections. It requires coordination with women's health programs providing services outside of the reproductive period as well as greater focus on prevention and development of healthy behaviors from childhood on. Fatherhood initiatives as well as the growing Men's Health program will be integrated. The BFCH is currently developing enhanced programs focused on the prevention and early identification of chronic diseases such as diabetes, heart disease, and asthma. Each of these is being linked with MCH programs to assure integration and coordination.

Children and Adolescents

Mortality

This section summarizes data for children, adolescents, and young adults ages 0 - 24. Greater detail on infant mortality (rates, causes, disparities) has been presented in the preceding section, but will be included here for some items as well.

Overall, the number of deaths among persons ages 0 -24 has fallen steadily from 1980 to 1998 (the most recent data available) from 1,985 to 955. Deaths between ages 1 and 24 dropped from 1,237 to 541. (See Figure 5.3.8-11 in Supporting Document 5.3.8.) Among 1-14 year-olds, the leading causes of death in 1998 were unintentional injuries-excluding motor vehicle injuries (27 deaths), cancer (19 deaths),

congenital anomalies (11 deaths), and motor vehicle-related injuries (11 deaths). This grouping of causes has remained relatively unchanged since 1990, with some shifts in the relative positions of each cause. From 1990 until 1998, the fifth leading cause was homicides, followed by suicides. For the first time in 1998, more suicides than homicides occurred in this age group (7 vs. 4).

For persons ages 15-24 years, injuries accounted for 74% of the deaths in 1998. Injuries accounted for the top five leading causes of death in this age group: Motor vehicle-related injuries (123 deaths), suicides (66 deaths), homicides (46), and unintentional injuries excluding motor vehicle injuries (41 deaths). Since 1990, cancer had been the fourth leading cause until 1998. Until 1996, homicides ranked second above suicides; this change in rank is the result of a clear drop in the number of homicides (96 in 1990; 79 in 1995, 41 in 1998) with no similar trend in the number of suicides. Motor vehicle-related injuries have dropped for the overall age group, but they have been rising since 1995 for the 15-19 year old age group. (See Figure 5.3.8-12 in Supporting Document 5.3.8.)

The number of deaths from all unintentional injuries, motor vehicle-related injuries, and suicides by race/ethnicity (white, non-Hispanic vs. all other race/ethnicity) for several age groups are displayed in Figures 5.3.8-13, 5.3.8-14, 5.3.8-15, and Figure 5.3.8-16 in Supporting Document 5.3.8. [Accurate age-specific rates by race/ethnicity are not available for intercensal years at this time.] The most notable discrepancy is the recent rise in the number of motor vehicle-related deaths among white, non-Hispanic 15-19 year olds. Also notable is the rise in the number of suicides in all age and race/ethnicity groups over the latest two years.

There has been no pattern of change since 1990 in the distribution of the types of cancer causing death. For the 1-14 year old group, the major causes have been and remain leukemia, brain and nervous system, and non-Hodgkin's lymphoma. For the 15-24 year old group, the major causes of cancer deaths have been leukemia, melanoma of the skin, brain and nervous system, and non-Hodgkin's lymphoma.

Both the number and age-specific rate of hospitalizations among children and youth have dropped from 1990 to 1998. (See the section on asthma below for a major cause of hospitalization in childhood.)

Adolescent Health Risks and Risk Behaviors

The Massachusetts Youth Risk Behavior Survey (MYRBS) is conducted every two years the Massachusetts Department of Education with funding from the CDC. MYRBS is a self report survey administered to 9th-12th grade students in randomly selected public high schools in Massachusetts, and monitors a wide array of behaviors of high school students that are related to the leading causes of morbidity and mortality among youth and adults. The most recent MYRBS was conducted in the spring of 1999. Because of the high response rates, the results can be generalized to apply to public high schools across Massachusetts. While these results cannot be considered representative of other adolescents (e.g.

younger adolescents, those in private schools, those not in school), they are the best and most comprehensive data available about many adolescent behaviors and risks. Because MYRBS is part of a national system, the results can be compared to national benchmarks in several areas. MYRBS data therefore will comprise the vast majority of data presented in this needs assessment summary. Some key findings, showing rates over the last three surveys (1995, 1997, and 1999) are displayed in Figure 5.3.8-17 in Supporting Document 5.3.8.

Tobacco Use

- 67% have tried smoking cigarettes at least once (lifetime cigarette use). In the month prior to the survey, 30% smoked cigarettes at least once (recent smoking), and 13% smoked cigarettes every day (daily smoking).
- After rising substantially from 1993 to 1995, rate of lifetime, recent, and daily smoking have all begun to decline. Smokeless tobacco use has dropped steadily since 1993 to a rate of 5% in the last month in 1999.
- Of students who had ever been regular smokers, 73% have tried to quit at least once, but only 17% have been successful.

Alcohol Use

- Recent alcohol use (past 30 days) and heavy alcohol use (5 or more drinks in a row in the past month), which had risen from 1993 to 1995, have leveled off since then.
- 52% reported having an alcoholic drink in the previous month. One third (33%) engaged in at least one episode of heavy (binge) drinking during that time. These rates are higher than current national baseline data (from different survey sources) reported for Healthy People 2010; the 2010 target for adolescent binge drinking is 8.3%. This is a significant problem in Massachusetts.
- Recent and heavy alcohol use were more common among male than female students, and among White students than youth of other races.
- Alcohol use was associated with illegal drug use, fighting, and suicide attempts
- For female students, recent alcohol consumption was strongly associated with dating violence and unwanted sexual contact.

Illegal Drug Use

- 47% of high school students have never used an illegal drug.
- Half have tried marijuana at some time; 10%/8%/4% have used cocaine, inhalants, or heroin, respectively, at some time.

- Cocaine use has increased significantly since 1993; inhalant use has dropped significantly.
- Illegal drug use was substantially lower in urban than in suburban and rural communities.

Violence-Related Behavior

- Rates of physical fighting and weapon carrying have declined significantly since 1993. In 1999, 37% of youth reported being in a fight the previous year (vs. 42% in 1993) and 15% reported carrying a weapon the previous month (vs. 20% in 1993).
- 9% had been threatened or injured with a weapon at school in the past year, and 6% had skipped school in the past month because of feeling unsafe.
- One in ten students reported being involved in a gang.
- 12% had experienced some form of dating violence, and 11% had experienced sexual contact against their will. Significantly more female than male adolescents experienced both of these.
- All violence-related behaviors were higher among males and among students in the earlier high school grades. Sexual minority adolescents reported substantially higher rates of school-related violence than their peers did.
- Urban, rural and suburban youth were roughly equal in terms of weapon carrying, gang involvement, and physical fighting, but urban students were the most likely to report having skipped school in the past month because of feeling unsafe.
- Patterns of violence-related behavior varied by ethnicity, with rates being highest among adolescents of Other/Mixed Ethnicity.
- Students who had carried a gun in the past month were more likely than their peers to have attempted suicide in the past year (35% vs. 7%).
- Adolescents who had ever experienced sexual contact against their will exhibited substantially higher rates of many risk behaviors than did other adolescents (including recent binge drinking, lifetime cocaine use, suicide attempt within the year, and use of dangerous weight-loss methods).

Sexual Behaviors and AIDS Prevention Education

- Rates of sexual risk behavior continue to decline slightly. Fewer students in 1999 than in 1993 reported lifetime sexual intercourse, four or more lifetime partners, or sexual initiation before age 13. Fewer than half (44%) have ever had sexual intercourse.
- Among sexually active adolescents, condom use increased from 1993 (52%) to 1999 (57%).
- One in 18 students (5.5%) self-identifies as gay, lesbian, or bisexual and/or has had same-sex sexual contact.

- Students who have received AIDS prevention education (93% of total) have lower rates than their peers of recent sexual intercourse, multiple partners, and being/getting someone pregnant.

Suicidal Behavior

- Suicidality among students appears to be declining. Fewer adolescents in 1999 than in 1993 reported seriously considering suicide or making a suicide plan.
- In the year prior to the survey, 30% had felt hopeless and sad for an extended period (were depressed), 21% had seriously considered suicide, and 8% had made a suicide attempt. Depression was more common in Other/Mixed Ethnicity (42%), Asian (35%), and Hispanic adolescents (34%) than among White (29%) or Black (27%) youth.
- Rates of suicidal thinking and attempts were higher among females than males. Suicidality declined with age/grade; ninth grade students were significantly more likely to have made a suicide attempt than 12th grade students.
- Youth who have been victimized at school and those who believed there was no teacher or staff member they could talk to about a problem were far more likely than their peers to have made a suicide attempt.
- Sexual minority youth reported significantly higher rates than their peers of suicidal thinking, suicide attempts, and more serious suicide attempts (those requiring medical attention).
- Rates of suicidal thinking and behavior were similar in urban, rural, and suburban districts.

Behaviors Related to Unintentional Injuries

- Seat belt use has increased significantly in the past 6 years. In 1999, 24% reported rarely or never wearing a seat belt, compared to 41% in 1993.
- Most students (83%) who rode a bicycle in the previous year reported never or rarely wearing a helmet. Even so, this represents an improvement in helmet use since 1993!
- In the month prior to the survey, 33% of adolescents rode with a driver who had been drinking alcohol, and 14% had driven after drinking alcohol themselves. Neither of these rates has changed significantly since 1993 but they are better than national rates. The Healthy People 2010 baseline for 1997 for riding with a driver who had been drinking is 37%, with a 2010 target of 30%.
- Black adolescents were more likely than youth of other ethnic groups to fail to wear seat belts. Failure to wear seat belts was significantly higher among urban than suburban or rural students (30% urban , 20% suburban and rural)

- White and Other/Mixed Ethnicity students had the highest rates of riding with a driver who had been drinking and of driving after drinking themselves. There were no substantial urban/non-urban differences in these risk behaviors.

Dietary Behavior and Physical Activity

- According to weight/height ratio (Body Mass Index), 15% were at risk of becoming overweight and 7% were definitely overweight. Black and Hispanic students were more likely to be at risk of overweight than youth of other race/ethnicity. Urban students were more likely than suburban or rural youth to be definitely overweight.
- The percent of adolescents believing themselves to be overweight rose from 28% in 1995 to 33% in 1999. At the time of the survey, 44% were trying to lose weight.
- Although exercise and diet were the primary weight control methods, a minority reported use of the potentially dangerous strategies of diet pills (7%) or vomiting/taking laxatives (7%).
- Females were significantly more likely than males to describe themselves as overweight and to have used different methods of weight control/weight loss.
- 63% engaged in vigorous physical activity at least three times in the week prior to the survey. This rate is in line with national YRBS data of 64% in 1997; the Healthy People 2010 target is 85%, a very ambitious target.
- 56% played on a sports team the past year.
- Participation in school physical education dropped sharply from 1993 (80%) to 1999 (61%).
- All forms of physical activity were lower for 12th than for 9th grade students.

Key Findings (excerpted from Department of Education Executive Summary)

- **Many adolescent risk behaviors have decreased with the past few years.** Significant improvements can be seen for physical fighting, weapon carrying, inhalant and smokeless tobacco use, suicidal thinking, and failure to wear a seat belt or bicycle helmet. Positive trends can also be seen in declines in cigarette smoking, riding with a drinking driver, and many sexual risk behaviors. Although some negative findings are reported – an increase in cocaine use and in perceptions of being overweight, and a decrease in physical education and sports team participation – overall the results are highly positive.
- **However, The majority of high school students engage in some risk behaviors that pose serious threats to their health and safety.** Frequent alcohol use, cigarette smoking, and fighting are common. A smaller number of youth drive after drinking, plan or attempt suicide, use marijuana or

other illegal drugs, and/or engage in drastic and dangerous weight loss strategies. Many adolescents are failing to develop the physical exercise and nutritional habits that will lead to a healthy adult life.

- **Risk behaviors tend to cluster together.** Students who engage in one high-risk or health-compromising behavior are often likely to engage in other risk behaviors as well. This reinforces the MDPH and DOE philosophies that a comprehensive approach to health education and health promotion, rather than programs targeting specific risk behaviors in isolation, is most appropriate. This clustering also reveals the important interrelationships between one risk behavior (e.g. drinking) and other health consequences (e.g. dating violence).
- **For some adolescents, risk behaviors began well before high school.** Substance use and sexual activity can begin in the pre-teen years. Thus those comprehensive health education and prevention programs must begin in elementary school and continue throughout the high school years.
- **Patterns of risk are different for different adolescents.** Gender, race/ethnicity, grade level, sexual orientation, kind of community (urban, rural, and suburban) and other factors are all related to variations in risk behavior. In some cases, targeted programs may be appropriate.

The Bureau will continue to make the reduction of adolescent risks and risk behaviors a priority and will continue using chlamydia rates among females ages 15-19 as one of our state performance measures.

Chronic Health Problems and Risks

Obesity: Trends in the U.S. and Massachusetts

Between 1991 and 1998, the prevalence of obesity in the U.S. increased by 49%; approximately 18% of the total population is obese. CDC has called this a unique situation of epidemic proportion in chronic disease. This trend of dramatically rising prevalence applies to children and adolescents as well as adults. One striking piece of evidence is the recently reported increase in the diagnosis of Type 2 diabetes among teenagers, a disease rarely seen before middle age in earlier eras. [JAMA, Fall 1999 and NY Times, May 1, 2000] Although we do not have detailed epidemiologic data from Massachusetts, information from health professionals and other sources suggest that we are part of this alarming challenge.

- 1996 PNSS data from Massachusetts WIC Programs indicate that approximately one-third (32.3%) of WIC participants were overweight prior to becoming pregnant and that 46.9% of WIC participants had excessive weight gain during pregnancy.
- A 1996 CDC report using Massachusetts birth data found a prevalence of high birthweight infants delivered to women ages 20 to 49 ranging from 10 to 15%, compared with a prevalence of low birthweight ranging from 5.9 to 7.9%.

- 1996 PedNSS data from Massachusetts WIC showed a greater proportion of overweight in Massachusetts than nationally, among all ethnic groups.
- The 1999 Massachusetts Youth Risk Behavior Survey (MYRBS) of students in grades 9 – 12 collected information for the first time that enabled calculation of Body Mass Index scores. Findings indicated that 15% of Massachusetts adolescents are at risk of becoming overweight and 7% are definitely overweight. Actual overweight was more common among males than females, but females were more likely to view themselves as overweight and to use a variety of weight control methods. [See section above on Adolescent Health Risks and Risk Behaviors for additional findings from the 1999 MYRBS concerning dietary behaviors and physical activity.]

Childhood Asthma

Current needs in childhood asthma are difficult to estimate precisely as data on childhood asthma prevalence and incidence are poor. While the total number of deaths from asthma and age-adjusted death rates have remained relatively unchanged over the last decade, there is evidence that the age-specific rate for children may be rising. Massachusetts has had between 124 and 100 total deaths each year from asthma between 1989 and 1998 (the number in 1998 was 119), or age-adjusted mortality rates of 1.41 to 1.0 per 100,000 population (the rate in 1998 was 1.29). In the five-year period 1994-1998, there were a total of 19 deaths from asthma among children ages 0-19, a five-year age-specific rate of 0.24 per 100,000. This compares with 12 deaths in the preceding five-year period of 1989-1993 and a five-year age-specific death rate of 0.15 for that period. This rise may be due to single year (1994) in which 7 deaths from asthma in children under 20 occurred; the number per year has been 3 or fewer in 8 of ten years in the last decade and only one death occurred in 1998. Because deaths from asthma occur so rarely, tracking death rates does little to assess overall changes in prevalence, care management, or severity.

Overall asthma mortality rates in 1990 (all per 100,000) by race/Hispanic ethnicity indicate significant disparities in the burden of disease: White, non-Hispanic – 1.7; Black, non-Hispanic – 4.7; Hispanic – 2.4; and Asian/Pacific Islander – 2.1. Although race/ethnicity-specific rates cannot be calculated for more recent years, the numbers of deaths by race/ethnicity indicate that this pattern has not changed.

The hospital discharge rate for asthma for all ages was 134.4 per 100,000 population in 1997; this met the Healthy People 2000 goal of no more than 160.0. Asthma hospitalizations fell 24.4% between 1994 and 1997; this decline is more than three times greater than the decrease in total hospitalizations for the same time period. The hospital discharge rate for asthma for children under 15 was 211.7 per 100,000 population; this also was below the Healthy People 2000 target of 225/100,000. The decline in the

number of hospitalizations for asthma among children under 15 was also pronounced, with hospitalizations for asthma falling more than two times more than the number of total hospitalizations for children in this age group. This trend in Massachusetts is counter to the national increases reported over time. We do not believe that these statistics, however, present an accurate picture of the impact of asthma among Massachusetts' children or its impact relative to other childhood disease. Because hospital discharge data do not capture emergency room or observation unit stays, we strongly suspect some of the decrease is due to changes in how acute asthma episodes are handled in a managed care environment, rather than a true change of this magnitude in the level of uncontrolled asthma.

Asthma is known to be a serious problem in many cities in the Commonwealth, and has been shown to cluster in areas with environmental "triggers" such as dilapidated housing with damp or musty conditions and air pollution (including incinerators). In Boston, where asthma is the number one reason children miss school, the city has identified nine zip codes where children younger than 5 are hospitalized for asthma more often than the citywide rate of 11.1 per 1,000. Of these areas, 6 are in Roxbury and Dorchester; the others are Chinatown/South End, East Boston, and Jamaica Plain. The City recently received a large HUD Healthy Homes Initiative grant to improve housing conditions for families with children with asthma. (Boston Globe, February 24, 2000; p. B5).

Approximately one-fourth of asthma hospitalizations are among children under ten years of age, a ratio that has remained virtually unchanged for the last decade. The rest are distributed across all other ages with frequencies declining steadily from age 10 through adulthood. The age distribution of asthma hospitalizations in Massachusetts is different from that of the United States overall, with more hospitalizations nationally concentrated in childhood (41.5% under 15 in the United States in 1995 vs. 29.9% in Massachusetts in 1993-1997. The reasons for this difference are not known.

The need for asthma care and prevention is also demonstrated in school health databases. Asthma was the most frequently reported chronic conditions (11.9% of all clients) in the 9,825 children and youth seen in school-based health centers in 1998-99. This was an increase from 6.8% in 1995-96.) Of the subgroup that responded to the chronic health question on the registration form, 13.9% reported having asthma (1,168 of 8,360). Of all clients who reported having a chronic health problem, 58% reported having asthma (1,168 of 2,006 children with some chronic health problem). Of all school-based health center visits, 3.5% were for an asthma-related reason; this percentage has remained the same since 1995-96. Data submitted on 183,525 Massachusetts students in enhanced school health services programs between January and April 1997 revealed that 40% of the 10,592 children on at least one prescription medication were using a prescription drug to control asthma. As the number of schools in Massachusetts with school-based health centers, enhanced school health services programs, or both continue to increase (through substantially increased state-funded support for these models that began mid-way through the

1999-2000 school year), the availability of data on the prevalence and management of asthma among the majority of school-age children will continue to expand.

The BFCH is working jointly with DPH Department of Environmental Health and developing a plan to study this issue in an organized, comprehensive manner. A previous developmental state performance measure related to asthma has been dropped, but asthma remains an area of high concern and will one of the growing child health problems addressed in a new priority need.

Childhood Lead Poisoning

Under the leadership of the Department of Public Health Childhood Lead Poisoning Prevention Program, the Commonwealth is recognized as a national leader in screening young children and working to provide lead-safe housing. However, lead poisoning continues to be one of the greatest environmental health threats to children in Massachusetts. Differentiation between blood lead levels considered to be lead poisoning (≥ 20 mcg/dL), elevated (20 - 24 mcg/dL), and moderately elevated (15 - 19 mcg/dL) has increased early case identification, intervention, and prevention of the progression of elevated blood levels to true lead poisoning. At the same time, research has continued to expand our understanding of the serious effects posed to growing children by lead exposure at even low levels of exposure.

During the last decade, there has been a decrease in the prevalence of both lead poisoning (blood lead levels of 25 mcg/dL or above) and elevated lead levels (blood lead levels of 20 - 24 mcg/dL) among children ages 6 months to 6 years. The combined statewide incidence of levels greater than or equal to 20 mcg/dL fell to a low of 2% of those screened in 1999.

Lead poisoning and elevated lead levels occur throughout the state but are concentrated in older urban areas where environmental risks are the greatest. Based on the 5-year (1994-1999) incidence of elevated lead levels (20 mcg/dL and above), the 20 high risk communities in Massachusetts are shown on the map in Figure 5.3.8-18 in Supplemental Document 5.3.8 High-risk communities are defined as those with at least 20 cases and adjusted rates of elevated lead levels no less than the state 5-year rate of 3.1%. Over 25% of all cases of lead poisoning and elevated lead levels occur in the Boston DPH Region (Boston, Brookline, Chelsea, Revere, and Winthrop) which has only 11% of the population under age 5, whereas the primarily suburban MetroWest Region, with 22% of the under 5 population, has less than 10% of the cases.

Oral Health

While there are no recent statewide data on the overall oral health status of children and youth, findings from selected community screenings and testimony presented in statewide hearings confirm the general picture found in national data - children from low-income and minority communities have significant

unmet dental care needs. In several low-income urban areas, dental screenings found that 38-48% of children needed restorative dental care, with 9-14% requiring immediate referral for treatment. Students at one Boston high school had four times as many cavities as the national average. Only 12-23% of children examined had dental sealants. The rate of orofacial injury is high- 22% of high school students surveyed at a Boston high school had dental trauma.

There are no Massachusetts-specific data on oral health status of pregnant women. However, this is an area of concern given recent research pointing to the possible connections between periodontal infection and low birth weight in infants of affected mothers.

Other Child Health Status Indicators

Data on a number of other child health status indicators are provided in various performance measures and Health Status Indicators. Specifically see PM #5 for Immunization rates; SPM #06 and Core Health Status Indicator #03A for female teen chlamydia rates., and Developmental Health Status Indicators #03B (additional STD data), and #09A / 09B (miscellaneous demographic data).

In Developmental Health Status Indicator #09, we were unable to report on several items as defined in the measure but have related information which is presented below.

- **Children in TANF families.** The readily available data from the Department of Transitional Assistance (which operates the Massachusetts TANF programs) are reported by *cases* rather than by individuals. Since the measure is developmental at this time, we did not ask DTA to conduct special data analyses for this application. We will follow up with them to determine if the data for this item and on Food Stamps could be generated for future applications and tracking. We can report that as of May 2000, there were 43,267 open Transitional Aid to Families with Dependent Children cases in Massachusetts. Of those cases, 6.6% have a reference member (presumably the mother) under age 20. By race/ethnicity, 44.5% of the case units are white, non-Hispanic; 18.5% are black, non-Hispanic, 31.4% are Hispanic, and 5.5% are other race/ethnicity.
- **Food Stamp Program participation among children.** The readily available data are for *cases and total recipients* without further break outs by the age of the recipients. As of May 2000, there were 114,999 open cases, which include 240,903 recipients. Further discussion of both TANF and Food Stamps participation in relation to the impact of welfare reform on families in Massachusetts can be found later in the combined Section 3.1.2.2 / 3.1.2.3. As noted above, we will attempt to get more information from DTA on the age and race/ethnicity of their caseloads.
- **Juvenile Crime Arrests.** Reliable state data of total juvenile crime arrests are not readily available. Analyses of national crime data for the Annie E. Casey Foundation and reported in its most recent **Kids Count 2000** do give some related data for Massachusetts. Kids Count 2000 reports that

Massachusetts had juvenile violent crime arrest rate (per 100,000 youth ages 10-17) of 543 in 1997, and a juvenile property crime arrest rate of 976 for the same period. Their data do not provide a total juvenile arrest rate and are not broken out by race/ethnicity. The reported Massachusetts violent crime rate is higher than the U.S. average of 412, while the property crime arrest rate is substantially lower than the national average of 2,338.

Child Abuse and Neglect In 1997, 102,777 reports of child abuse or neglect were filed with the state Department of Social Services. These reports represent an unduplicated count of 69,429 children reported. There were 58,368 investigations of abuse or neglect and 29,555 verified investigations; investigation reports are not an unduplicated count of children.

Children with Special Health Care Needs and their Families

Estimates of the Population of Children with Special Health Care Needs

Massachusetts did not develop independent estimates or surveys of the population of children with special health care needs (CSHCN), choosing to wait for the national MCHB-sponsored survey that will be underway shortly. For this needs assessment process (which has been incorporated into a number of planning processes for Bureau programs and services), we have utilized the application of estimates from several data sources, applying them to the estimated 1997 population under 18 in Massachusetts of 1,428,295¹. Estimates were also made for each of the 6 Public Health Regions in the state, as this is the organizational model for our primary interactions with most families.

Originally, estimates according to six definitions of “special health care needs” were made. All six are presented at the state level, and the most relevant are also presented by region. The estimates examined are listed below, in order by declining prevalence estimates:

- 1) “Children with Chronic Physical Conditions”² – estimated prevalence rate of 30.8%, or 439,344 children
- 2) “Children with Existing Special Health Care Needs”³ – estimated prevalence rate of 17.3% for the Northeastern Region of the U.S., or 247,095 children. This is the number of children with special health care needs used elsewhere in this report and application as the denominator when the statewide number of CSHCN is called for.
- 3) “Children with any Activity Limitation”⁴ – estimated prevalence rate of 6.4% or 90,268 children.

¹ Massachusetts population estimate from MISER (Massachusetts Institute for Social and Economic Research), using 1997 population estimates, single year of age files; released in January 2000.

² 1988 National Health Interview Survey (not including institutionalized population). A condition was considered chronic is (1) the respondent indicated it was first noticed more than 3 months before the interview date, or (2) if was a type of condition that ordinarily has a duration of more than 3 months, such as diabetes, heart conditions, and arthritis. Reference: Newacheck PW, Taylor WR. Childhood chronic illness: prevalence, severity, and impact. *Am J Public Health.* 1992; 82:364-371.]

³ 1994 National Health Interview Survey on Disability (not including institutionalized population). Modified from the federal MCHB definition (“Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”) The modified figure excludes “at increased risk.” Reference: Newacheck PW, Strickland B, Shonkoff JP, Perrin JM, McPherson M, McManus M, Lauver C, Fox H, Arango P. An epidemiologic profile of children with special health care needs. *Pediatrics* 1998 Jul;102(1Pt 1): 117-23.

⁴ 1992-1994 National Health Interview Survey (average annual prevalence; not including institutionalized population). Activity limitation (disability) was defined as “a child’s ability to perform the usual activities associated with the child’s age group, such as school or play, are compromised by a chronic condition.” Reference: Newacheck PW & Halfon N. Prevalence and impact of disabling chronic conditions in childhood. *Am J Public Health.* 1998;88:610-617.

- 4) “Children receiving SSI”⁵ – estimated prevalence rate of 1.1%, based on SSI reported total of 15,410 as of December, 1999.
- 5) “Children with Limitation in Activities of Daily Living (ages 5-17 only)”⁶ – estimated prevalence of 0.9%, or 9,214 children.
- 6) “Children in Long Term Care Institutions” (1990 Census data) – estimated prevalence of 0.14%, or 2,000 children.

Table 5.3.8-3 in Supplemental Document 5.3.8 displays data for the state and for the six Regions for estimate (2), the MCHB modified definition, with estimated numbers of children by age, gender, and race/ethnicity. Table 5.3.8-4 in Supplemental Document 5.3.8 displays similar estimates based on estimate (3), children with any activity limitation. Table 5.3.8-5 in Supplemental Document 5.3.8 displays the estimated number of children statewide with specific chronic conditions, based on estimate (1). While this estimate is considered too inclusive based on the recommended MCHB definition, it can be useful in getting a sense of the frequency with which this broader group of children with chronic health problems may be seen in primary care and school settings.

Another source of information about the population of children with special health care needs is enrollment data from the Massachusetts Early Intervention Services system. EI served over 20,000 children under age three in 1999. Figure 5.3.8-19 shows the percent of children enrolled by EI eligibility category (established condition, developmental delay, at-risk, and clinical judgment). Children eligible for multiple reasons are assigned to the “highest” level applicable). Eleven percent of the children enrolled have an established condition, and 75% have developmental delay. The number of children with autism and pervasive developmental disorder enrolled in EI has increased by 35% from FY92 to FY99, from 1.7% to 2.3%. (See Figure 5.3.8-20 in Supplemental Document 5.3.8.)

⁵ 1999 Social Security Administration data. SSA definition of Disability: “A child may be eligible based on disability if s/he has a medically determinable physical or mental impairment(s) which results in marked and severe functional limitations; demonstrated by medically acceptable evidence (e.g. clinical and diagnostic techniques). The impairment(s) must have lasted, or be expected to last, for at least one year, or result in death.”

⁶ 1994 National Health Interview Survey on Disability (not including institutionalized population). Limitation in the Activities of Daily Living (ADL) is defined as having difficulty for 12 months or more with bathing, dressing, eating, or toileting. Reference: Federal Interagency Forum on Child and Family Statistics: America’s Children 1999.

Birth Defects

Over the past two years, the birth defects state surveillance program, conducted by the Massachusetts Center for Birth Defects Research and Prevention in the BFCH, has been collecting data on cases of birth defects in the state. Table 5.3.8-6 in Supplemental Document 5.3.8 presents count estimations of birth defects calculated from the combined 1990-1994 rates of the Metropolitan Atlanta Congenital Defects Program (MACDP) and the number of 1998 Massachusetts births. The MACDP is considered the “gold standard” among birth defects surveillance programs, having collected data since 1967 using the most comprehensive ascertainment methods to date. The defect categories are derived from the National Birth Defects Prevention Study (NBDPS), an eight-state collaboration that is the largest national study to understand the causes of birth defects. These estimates are then compared to the actual cases, collected by the Massachusetts surveillance program, for births for the 12-month period October 1998 through September 1999.

Out of 29 defect categories, 19 had a 40% or higher agreement between the estimated and actual counts. Some of the differences between counts may be due to differences in surveillance activities. MACDP has a more aggressive approach, with nurses investigating nursery logs, delivery logs, and birth records, and actively looking for birth defects in hospitals, outpatient clinics, and genetic clinics. In Massachusetts, we are limited by our statutory authority to examine only records of cases reported to the Department by birthing hospitals. In addition, certain congenital anomalies counts such as neural tube defects, renal agenesis, and single ventricle are affected by elective terminations. The Massachusetts program does not collect termination data and there is therefore a larger discrepancy between estimated and actual counts for these defects.

Table 5.3.8-7 in Supplemental Document 5.3.8 presents the regional distribution of birth defects cases, 1998 births, and controls randomly selected for the NBDPS. State surveillance includes a broad range of birth defects and the NBDPS cases are in essence a subset from the overall state surveillance pool. The table shows that the distribution of birth defects cases from state surveillance and the national study closely align with the regional distribution of births. These results are reassuring as to the consistency of the overall reporting activities of birth hospitals throughout the state.

Based on the study, we can estimate that slightly less than 1% of the 1998 births carried a birth defect diagnosis, a percentage lower than the 3 to 5% average often noted for congenital anomalies. It is more likely that this is due to the constraints and limitations on the birth surveillance system than to a true lower incidence of birth defects in Massachusetts. Efforts to improve the surveillance system and to understand the relationships between Massachusetts data and national norms will continue in FY01.

HIV/AIDS in Women and Children

For children, the Pediatric Spectrum of Disease study (PSD) has served as a substitute for HIV reporting in the state. PSD is a natural history study that has tracked perinatally exposed children in Massachusetts and other states since 1989. PSD currently reports 236 children alive with HIV who are actively followed in Massachusetts, a higher number than ever before in the epidemic. This reflects marked declines in HIV deaths as a result of improved treatment among children. In fact, the median age among infected children in Massachusetts increased from 2.5 to 8.0.

PSD also serves as an important source of information on perinatal HIV transmission. These data reveal first, a large decline in the proportion of exposed infants born infected since 1994 when the results of the 076 study became available. In 1994, 13% of the exposed infants remained seropositive, by 1998 the percentage had dropped to 3%. These data also reveal the high proportion of women who chose to receive prophylactic ZDV or combination therapy for prevention of mother to infant transmission during this period. In 1991 97% of HIV+ women were not receiving any therapy during pregnancy, by 1998 that figure had dropped to 3.6%

Supplementing PSD data, interviews with caregivers of women who gave birth to infants with HIV infection between 1994 and 1998, provide insight into system gaps that leave some families vulnerable to perinatal transmission. While 17% of childbearing age women in Massachusetts in 1997 were born outside the US, the proportion of foreign born women among those had infected children was greater than 50%. While there is no baseline available for comparison, it is also striking that at least 3 of the ten women studied had clearly had a prior HIV test. These two attributes of mothers of infected newborns suggest issues to be addressed in perinatal prevention efforts.

The information base we can use to target provider training and consultation come from two sources. The Massachusetts Perinatal Provider Survey, conducted in 1996 and replicated last year, reveals the extent of counseling, offering HIV tests, and testing by providers in relation to provider and caseload attributes. Data from the 1996 survey indicated that providers counseled an average of 67%, offered an HIV test to 73% and tested 39% of patients in 1995. Preliminary analysis of 1998 data indicates that these figures rose to 86%, 92% and 55% respectively. Both rounds of the survey showed wide discrepancies among providers, with those in smaller private practices counseling and testing less than those in HMO's, hospital clinics, or community health centers. Further analysis of the 1998 data will permit MassCARE to target interventions based on geography and hospital affiliation of respondents.

The Early Intervention Program, which serves children between the ages of birth and 3 whose developmental patterns are atypical or are at serious risk to become atypical through the influence of certain biological or environmental factors in their natural environment, is one of the key BFCH programs for CSHCN. This is a universal program currently serving over 20,000 children annually. The majority of the children have a defined delay or established condition. Over the past three years, there has been an

increased prevalence by physicians of diagnoses of autism and pervasive developmental disorder (PDD). The EI program provides a profile of children who may need additional services both from the medical and educational systems in future years. To further enhance this service, the BFCH funded 7 Regional Consultation Programs comprised of multidisciplinary teams with expertise in servicing children with complex medical needs, particularly those who require life-sustaining medical technology. The Consultation Programs assist community EI programs in the design and implementation of services in the context of the Individualized Family Service Plan and act as a resource to all child-serving programs in their catchment areas.

Care Coordination for CSHCN

While Massachusetts offers a wide variety of services to chronically ill children, there is no system of care coordination other than Early Intervention for children 0–3 that guarantees that all families can make the best use of available resources. It is not uncommon for even medically experienced families to experience long delays before recognizing potential resources and assistance. Some primary care pediatricians have worked to create a “medical home” in their practice for chronically ill children. There is no statewide survey or registry of such physicians, however, and there are major challenges and obstacles to providing this coordinated care - primarily time, funding, and knowledge. A few specialty clinics provide coordinated care for children with particular conditions, such as asthma, cystic fibrosis, and sickle cell disease. The American Academy of Pediatrics now supports the development of interdisciplinary training in care coordination and home care for pediatric residents, but such efforts are in their infancy.

At least 8 different state programs provide varying degrees of care coordination to families with children with special health needs, but three major gaps have been identified:

- The system is not universal: after age three, when children do not qualify for Early Intervention. There is no one program that assures coordinated care to every chronically ill child. As a result, many children slip through the gaps in service eligibility, and there are long waiting lists for some state programs.
- The system is not accountable, as each program focuses on how well it serves those in its own program – not how well families overall are being served.
- The system is largely separated from clinical practice, as families interact with case managers, often bypassing physicians and nurse practitioners. A pediatric provider may have to interact with a different case manager for every child with SHCN in his or her practice.

All MCH Population Groups

Violence against Women and Children

During the last 10 years, domestic violence and sexual assault have come to be understood as serious public health concerns that are of particular consequence of traditional maternal and child health populations. In 1992 in response to the alarming number of cases of one of the most severe types of such violence, domestic homicide, the Governor of Massachusetts declared domestic violence a public health emergency and subsequently created the Governor's Commission on Domestic Violence. And yet, we know that homicide is only the tip of the iceberg of violence against women and children. There is no shortage of data to support this claim:

- Between 1988 and 1997 rape crisis centers supported by the Department of Public Health received reports of more than 26,000 thousand incidents of sexual assault. The median age of women reporting rape and attempted rape was 20 years at the time of assault and 33% of assaults reported to rape crisis centers in 1997 involved adolescents age 13-19. ("Sexual Assault in Massachusetts" 1988-1997, MDPH)
- Preliminary data from the 1999 Massachusetts Behavioral Risk Factor Survey, an ongoing state-based random-digit-dial phone survey, show that 20.0% of women age 18-59 report being sexually assaulted and 33.4% of those were assaulted by an intimate partner. According to 1998 data, 10.5% of women who were pregnant within the last five years reported experiencing intimate partner abuse within the last year (as compared to 6.0% of women who were not pregnant within the last five years).
- The 1999 Massachusetts Youth Risk Behavior Survey, a self report survey administered to 9th-12th grade students in randomly selected public high schools in Massachusetts, found that 12% of all respondents had experienced some form of dating violence (18% of females and 7% of males); 11% had experienced sexual contact against their will at some time in their life (16% of females and 6% of males). The 1997 MYRBS reported that of teens who had ever been pregnant, 54.3% reported having experienced either physical or sexual violence by a date.
- In 1999 Massachusetts battered women's programs received 57,244 hotline calls, performed intakes for shelter or safe home services for 2,623 women, and turned away 3,934 women for services. (Jane Doe, Inc: The Massachusetts Coalition Against Sexual Assault and Domestic Violence)
- In 1998 there were 37,998 abuse prevention orders issued in Massachusetts Courts (Massachusetts Office of the Commissioner of Probation)
- In 1995 an estimated 43,000 children witnessed domestic violence in Massachusetts, sixty five

percent of these children were under the age of 8 years old. (Massachusetts Office of the Commissioner of Probation report)

These statistics, however, only begin to paint the picture of the health effects of such violence. The experiences of those who have worked in the field as well as emerging data tell a great deal about the physical and emotional effects of violence against women. In a study conducted by the MDPH STD Division between 1997 and 1999, 54% of patients seen in STD clinics reported past or current sexual violence. Overall, experience of sexual violence was highly associated with risk factors for STDs including number of partners and drug and alcohol use. Nationally, intimate partner violence is the single major cause of injury to women (Flitcraft and Stark, 1991) and is associated with many other serious health problems including depression, anxiety, post traumatic stress disorder, chronic pain, gastrointestinal disorders, substance abuse, HIV infection, suicide, and pregnancy complications (Smith et al 1995).

In a population based study, Dietz et al (1997) found that women who experienced physical violence were 1.8 times more likely to have delayed entry into prenatal care than women who had not experienced such violence. Grimstad, Shei, Backe, and Jacobsen (1999) summarized the physical consequences of violence during pregnancy: spontaneous abortion, placental abruption, fetal intracranial bleeding, and intrauterine death. Grimstad et al. (1999) cited that currently, low birth weight has not been associated as an outcome of violence during pregnancy consistently. However, they reported that among women with a low birth weight infant, the mean birth weight was 261g lower among those who reported any interpersonal conflict behavior during pregnancy.

Physical violence during pregnancy not only has physical effects on the mother and fetus, but also emotional consequences. Severe and less severe physical violence, threats, and verbal abuse can be psychological and emotional influences on a woman's sense of control of her life. There may also be long-term consequences of violence such as anxiety, stress, depression, and increased use of tobacco, alcohol, or drugs, which could affect pregnancy outcomes. Studies have found that severe physical violence to be associated with smoking during pregnancy and that women with unwanted or mistimed pregnancies were at greater risk of physical violence from their partners than were women with intended pregnancies, regardless of demographics. Physical violence may occur before conception and may be directly related to the unintended pregnancy.

The relationship between sexual assault and suicide for adolescents is also being better elucidated. Information from the 1997 Massachusetts Youth Risk Behavior Survey showed that, of respondents who had attempted suicide, 34.5% had a history of having been sexually assaulted; of those for whom the suicide attempt resulted in injury, 41.2% had such a history. [See section above on Adolescent Health Risks and Risk Behaviors for additional data from the 1999 MYRBS about violence among adolescents.]

The correlation can also be found from the “other side.” Of those females reporting sexual assault, 27.9% had attempted suicide and 12% had attempted suicide resulting in injury. This compares to a rate of 12.6% and 4.3%, respectively, for female adolescents who did not report having been sexually assaulted.

The effects of domestic violence and sexual assault are also clearly evident in the lives and health of children. An increasing body of literature demonstrates serious consequences for children who live in homes where there is intimate partner violence. In addition to the effects of witnessing violence, numerous studies show direct connections between domestic violence and child abuse. The largest study of this kind found that batterers are seven times more likely than non-batterers to frequently hit their children (Straus, 1983). In Massachusetts, a survey of mothers in battered women’s shelters found that at least 50% of children exposed to domestic violence had themselves been directly physically or sexually assaulted by their mother’s partner. Furthermore, the Massachusetts Department of Social Services, the state’s child welfare agency, reports that 40-60% of its 22,000 open child abuse and neglect cases involve violence against the children’s mother. The ways in which a child responds to the experience of being abused or of witnessing violence depends on many factors, including the severity and frequency of the violence, developmental stage, and resources for support within the child’s life. However, a number of studies and clinical experiences have demonstrated that the effects of witnessing domestic violence, as defined by symptoms associated with post-traumatic stress disorder, are as serious as those associated with being a direct victim of abuse.

Mental / Behavioral Health

Another area of concern that crosses all three population groups is mental health. Results from the key informant interviews, provider focus groups, and program specific information consistently and increasingly cite this concern from a number of perspectives. Home visitors in the FOR Families and MCH Home Visiting Programs report that maternal depression is one of the most significant concerns confronting the families with which they work and affects many other areas of health-related practices for the mothers and their children. This finding is supported by other current research. The May 2000 issue of *Pediatrics* reported that depressed mothers are less likely to employ recommended preventive practices for their children. The practices specifically studied included car seat use, covered electrical outlets in the home, availability of syrup of ipecac at home, and daily reading to their children. In addition to the impact of depression on the mother’s own self care and health behaviors, the potential impact on child injury, parent-child attachment, child development, and child abuse and neglect heightens the need to prioritize this critical component of maternal and child health. The mental health service system in Massachusetts will be discussed more fully in Section 3.1.2.3, but the clear and compelling gap for public health is in the area of primary prevention and health promotion. The National Bright Futures initiative

will focus on Mental Health promotion in a coming volume of its Bright Futures in Practice series, providing guidelines on mental health promotion and substance abuse prevention for infants, children, and adolescents.

ADD and ADHD have been identified by school nurses as two of the major problems of students. With the increasing diagnosis of these two conditions there also appears to be an increase in the number of prescriptions for various medications primarily psychotropic medications. Two additional trends which have been noted in regards to psychotropic drugs are a lowering of the age at which the medications are prescribed and the increased prescription for adolescents. Many children with diagnosed ADD and ADHD do respond in a dramatically favorable way to some medications, if the children are carefully diagnosed and other interventions occur concurrently. The following are issues, which have been identified that need to be addressed:

- Parents and school staff need additional information on the normal development of children and strategies to address some behaviors in both the classroom and the home. The University of Massachusetts/Simmons College School Health Institute is beginning to provide ongoing education in this area.
- When the child is perceived to have a behavioral/learning/developmental issue, there is a need for an intense physical and psychosocial evaluation of both the child and family before medications are prescribed; there may be other issues, which need to be addressed.
- A pediatrician/family practice physician rather than an expert in the field often prescribes the medications. There may be several reasons: (a) comprehensive evaluations are time-consuming and costly; (b) insurance may not cover them, (c) specialists in pediatric psychosocial/neurological medicine may not be available, (d) parents may request the medications because of the immediate impact of the child's behavior on the family, school, (e) parents may not have the time or motivation to undergo an intensive evaluation, etc.
- There is a need to increase the feedback on the effectiveness of the medication; we are working to promote the feedback mechanism among school health personnel, primary care providers and parents.
- Parents of children with ADD/ADHD need ongoing support and case management to "parent" and support their children; parent support groups are invaluable in this area.
- Some of the psychotropic medications have street value; hence there is the danger of diversion both in the schools and the home.

3.1.2.2 Direct Health Care Services (Combined discussion, as recommended)

3.1.2.3 Enabling Services

Massachusetts has extensive health care resources to provide primary and preventive care services to MCH populations. Overall there is approximately one full-time equivalent primary care physician for every 1390 residents. Physicians reporting primary care specialties make up about 28% of all licensed physicians. (However, only 22 physicians statewide report a specialty in adolescent medicine.) There is no public delivery system of primary care for MCH populations. Services are delivered almost exclusively in private practice or organized health care (e.g., staff model HMOs, community health centers and hospital outpatient departments) settings.

Within a general situation of overall adequate primary care physician supply, there are localized shortages in some urban and rural communities and for specific populations facing financial, linguistic or cultural barriers. The Primary Care Office (PCO) of the federal Bureau of Primary Health Care Primary Care Cooperative Agreement, located within the Division of Maternal and Child Health of the BFCH, conducts needs assessments for federal designation of Health Professional Shortage Areas (HPSAs) and Medically underserved Areas/Populations (MUA/Ps) in the state. There are 17 geographic or population primary care HPSAs, of which two are in rural areas. The others are for specific neighborhoods or the low-income populations of major urban areas with community health centers.

Massachusetts has a strong network of safety net providers, with its backbone being 49 community health centers that provide care in 100 sites in 24 of the neediest urban and rural communities. BFCH has also made a strong commitment to School Based Health Centers as an appropriate source of primary care for youth: there are now 35 funded operational SBHCs with 24 additional sites scheduled to open in September 2000 and 22 schools funded for a planning process.

However, these safety net providers are disproportionately concentrated in Boston, with 25 CHCs, and in urban areas in the eastern third of the state. Western Massachusetts, which is the most rural area of the state, has the fewest health centers or other safety net providers. The series of Rural Health Forums held in 1998-99 by MDPH identified specific issues related to access to care in many of these communities. Based on these forums, the Rural Health Workgroup, convened and staffed by the Director of the Office of Rural Health in the Division of MCFH, has made a series of recommendations internally, including supporting increased access to primary care services, hospital-based services, oral health care, school health, interpreter/translation services, and health insurance.

Contracts for the Bureau's MCH services historically have been given disproportionately to urban providers because of greater numbers of clients served, poorer health status indicators, and the lack of providers in rural areas available to bid for contracts. While absolute distances in Massachusetts are relatively short compared to many states, local rural and small town culture is such that many residents do

not travel to cities to receive these available services. The Rural Health Workgroup has identified that design of DPH bid requests for services and programming must become more sensitive to these needs. A MDPH plan to design a set of rural-specific health indicators will assist in this effort.

Availability of services in rural areas has improved in the past five years, due to local community efforts in conjunction with BFCH, the Office of Rural Health, the PCO, the PCA, and DPH CHNAs. Since 1997, a new CHC has opened in the heart of one of the northwest rural section of the state; another located in the southwestern corner of the state has recently received BPHC funding; and a third is opening in a small city in central Massachusetts that serves surrounding rural communities. On Cape Cod on the eastern Massachusetts coast, the CHC serving the outermost area of the Cape with two centers opened a third site to serve another community. Care for MCH populations is a significant component of the newly available services at each of these CHCs.

Smaller agencies frequently lack the infrastructure and staff to easily meet requirements for state clinic licensure requirements, to do ongoing grant writing and fundraising. In today's complex health care environment, it is very difficult for new community-based organizations to start in areas that lack infrastructure. The three rural CHCs, for example, have all partnered with existing urban CHCs in order to become operational.

Massachusetts funds several programs that recognize the unique role that CHCs play in providing care to underserved populations in the Commonwealth, and the BFCH collaborates through both state and Title V funding in contracting with CHCs to ensure that comprehensive services to at-risk women, children and adolescents are available:

- The state Uncompensated Care Pool allows CHCs to bill for their unreimbursed services to low-income uninsured individuals;
- CenterCare, administered by the Bureau's Division of MCFH, is a state-funded program enrolls uninsured low-income adults who receive their primary care at a community health center and reimburses the designated CHC on a capitated basis. As of June 2000, 8525 individuals were enrolled in CenterCare.
- The CHC Support and Enhancement Program, also administered by the Division of MCFH, provides state funding for operational support to CHCs. Funding for this program was increased by the state legislature in FY00 so that individual CHC grants have risen from approximately \$19,000 to \$69,000.
- The Combined Primary Care Program within the Division of MCFH funds 40 vendors, most of which are CHCs, for direct and enabling services to enhance basic primary care perinatal, pediatric and adolescent health programs. Nutrition, social services, outreach, and case management are the major services supported through this program.

While BFCH procedures for identifying communities and organizations in which to fund its direct and enabling services vary by individual program, indicators of population-based health status, demography, behavioral risk factors, and service accessibility particular to the individual target population are a major factor. The Bureau has devoted some effort to developing a composite index of high-risk communities (see Figure 5.3.8-24 in Supporting Document 5.3.8 for map) that has been used as part of WIC's and the Combined Primary Care Programs procurement criteria. Another index that uses some of the same criteria is eligibility for FIRSTLink (discussed further in Section 3.1.2.4, Population-Based Services). Further refinement of these and other indices to target high-risk populations would be valuable in decisions about effective resource allocation.

The number of hospitals and hospital beds has been declining in Massachusetts for more than a decade. There are currently 53 hospitals with licensed maternity units and two freestanding birth centers. In some areas of the state, proximity to a maternity hospital declined, although no community in the state is farther than about 30 miles from a maternity hospital. Since obstetricians tend to locate their practices near their delivery hospitals, women in some communities have been faced with travelling further to receive prenatal care.

Pediatric beds have also declined, in part to the declining need for inpatient hospitalization among children. There remains sufficient availability and distribution of specialized and tertiary pediatric services. However, children's hospitals nationwide are suffering financial problems and this is true in Massachusetts also. Children's Hospital in Boston, the premier children's hospital in the nation, is experiencing significant deficits in its operational budget. This is of concern because of its regional status as a resource for children with special health care needs and because it also serves as a community pediatric resource.

Rural hospital services are a particular area of concern. The Office of Rural Health in BFCH has received a Rural Hospital Critical Access grant from HRSA and is finalizing a state plan for submission to HCFA. Nine small rural hospitals are participating in the planning process. Two of these, on Nantucket and Martha's Vineyard Islands, are the only hospital providers on their respective islands.

Linkages of services among different levels of care

For CSHCN, there is an effective and generally adequate system of linkages among the different levels of care. However, with such a high percentage of CSHCN involved with managed care, consideration of issues about linkages must take into account this important aspect of the health care delivery system. The BFCH Division for SHN has played a central role in the establishment of the Massachusetts Consortium for CSHCN, which also includes representation from two pediatric tertiary care centers, parent organizations, DMA, DSS, and one MCO. The Consortium has undertaken a number

of activities to assess issues of managed care in the overall coordination of services for CSHCN, and has concluded that effective care coordination for individual families is an essential component of successful linkage to services. The Division for SHN has used these results and guidance from the Consortium in its proposed re-shaping of the family case management system into a care coordination system based in the medical homes of CSHCN.

The linkages among service levels within the perinatal health care system have not been adversely affected by managed care and continued to function effectively. The regionalized newborn nursery system is regulated by the MDPH Bureau of Health Quality Management. There are 17 level 2 nurseries and 8 level 3 nurseries across the state. Data on the percentage of VLBW infants delivered at facilities for high-risk deliveries and neonates show that the overall objective has been met. However, analysis of these data does indicate that further review of this system is needed in the southeast region. In conjunction with the Perinatal Advisory Committee, BFCH plans to conduct further analysis of this issue.

Against this backdrop of a strong network of high quality, not-for-profit community-based services, the Massachusetts health delivery system is stressed by many competing factors, with a widespread concern that substantive reforms and organizational support is needed to assure continuation of its strong tradition. The health care delivery system has been characterized by three major trends in the last half of the 1990s that have implications for providing accessible, quality services to infants, children, youth, and pregnant women.

- *Increased financial access to health services:* Interlocking state laws and programs to cover many more individuals and to bring more integration and collaboration to publicly offered health insurance coverage.
- *Growing concerns about managed care from consumers, providers and legislators:* concerns about patient and provider protections coupled with major financial problems at HMOs have driven efforts, still pending in the legislature, to pass legislation giving more oversight to HMO finances and operations.
- *Growing financial instability of the largely not-for-profit provider health care network,* particularly safety net providers, as hospitals and community health centers are affected by a variety of factors.

Increased financial access to health services

Massachusetts ranks 6th in the national for health insurance coverage, with 89.7% of residents reporting coverage in 1998. However, prior to 1998, the percent of residents with health insurance coverage had

been decreasing for a decade (from 93.7% in 1987 to 87.4% in 1997). This declining indicator - fueled by the recession of the late 1980s followed by restructuring and downsizing of benefit plans by employers even as the economy improved – led to a chorus of concerns in the Commonwealth from advocacy groups and health care providers. Hospitals in particular faced mounting financial burdens as the Uncompensated Care Pool, designed to cover their costs in providing care to uninsured individuals, was falling far short of need. Meanwhile increasing numbers of children had no coverage at all, and a state-only children’s preventive and primary care health plan created in 1991, the Children’s Medical Security Plan, had closed enrollment in 1994 due to budget constraints. MassHealth, the state Medicaid program administered through the Division of Medical Assistance (DMA), was already operating a managed care program on a HCFA 1915B freedom-of-choice waiver and had won approval from HCFA for an 1115 waiver in early 1995. However, implementation of it required passage of enabling state legislation.

Out of these various stresses to financial access that engaged diverse interests in the health care sector emerged three successive pieces of state health care legislation in 1996 and 1997⁷ that have set the framework for Massachusetts to move forward with improving financial access in a manner that also integrates implementation of the federal Title XXI Children's Health Insurance Plan (CHIP) and further implementation of DMA's 1115 waiver for managed care, including expanded eligibility for various populations.

In July 1997, DMA began the first reforms enabled through its 1115 waiver. These included discarding an 'assets test' and going to a simplified income-only eligibility determination, expanding eligibility for MassHealth Standard, its EPSDT benefit package that covers most optional services, to children through age 18 up to 133% FPL. In August 1998, MassHealth continued reforms under the 1115 waiver and implemented its CHIP coverage in a seamless, integrated program. MassHealth Standard expanded to cover children through age 18 with family incomes up to 150% of the FPL and pregnant women and infants up to 200% FPL.

As part of these expansions, a pre-existing insurance program for disabled children and adults, CommonHealth, was incorporated into MassHealth. Started in 1998 for children with special health care needs who meet SSI disability requirements but are above income eligibility, CommonHealth offers a sliding fee premium for coverage equivalent to MassHealth Standard. It also offers wrap-around coverage to income-eligible individuals with private health insurance. CommonHealth enrollees have the option of fee-for-service or managed care. There were 1167 children enrolled in CommonHealth during 1999.

⁷ Chapter 203, July 1996 - An Act for Improved Access to Health; Chapter 47, July 1997 - Uncompensated Care Pool Reform Act; Chapter 170, November 1997 - The Health Access Act of 1997.

A small but key component of the overall MassHealth expansion under both the 1115 waiver and CHIP has been to support private employer-based insurance to prevent 'crowd-out' of private insurance coverage by the availability of public coverage. The MassHealth Family Premium Assistance Program, implemented in August, 1998 is designed to encourage families from 151-200% FPL to keep or buy employer-offered insurance if available (according to certain benefit package stipulations) by offering assistance with premium payment.

For families between 150-200% FPL without access to the private employer market, the Family Direct Assistance Program allows them to be covered by MassHealth in a benefit package that is only slightly less comprehensive than MassHealth Standard. For both family assistance programs, there is a required co-payment for the monthly premium, which slides up to a maximum of \$30/month per family. (One cause for concern upon implementation was whether families would pay the premium. There are approximately 2700 children covered by Premium Assistance and 15,000 covered by Direct Assistance whose families must pay a premium. To date, approximately 7% of families have been disenrolled because of failure to pay premiums.)

Concurrent with these MassHealth expansions for children and adolescents, the state-only Children's Medical Security Plan (CMSP), which is administered by BFCH, collaborated closely with DMA on extensive efforts to ensure that families of children covered by CMSP were notified of expanded MassHealth benefits and given assistance in transferring coverage. As a result, CMSP transferred more than 25,000 children who became newly eligible for MassHealth.

CMSP continues to be available to any child age 18 or younger who is uninsured for primary or preventive health care and not eligible for MassHealth. Premiums are completely subsidized for families with incomes below 200% FPL and partially subsidized for families with incomes between 200-400% FPL. Those families with incomes greater than 400% FPL pay a market-rate premium. The distribution of CMSP enrollees by age group and in relation to the Federal Poverty Level are displayed in Figures 5.3.8-21 and 5.3.8-22 in Supporting Document 5.3.8.

CMSP benefits include preventive primary care and family planning with no co-payment. Small co-payments are required for sick visits, specialty consults, diagnostic or lab tests and emergency care (\$1000/year cap). CMSP also offers limited coverage for durable medical equipment, prescription medicines, and ambulatory mental health care. In 2000, CMSP expanded the limits on some of these benefits and also implemented coverage of dental services, as authorized in the 1997 legislation.

CMSP enrollment has begun to increase again, to almost 23,000 in May from about 18,000 in January 2000. BFCH is monitoring this situation and collaborating with DMA to understand whether this is an unexpected side effect of other factors (such as DMA recertification, welfare reform or increased benefits for CMSP).

DMA also expanded eligibility for prenatal MassHealth benefits to pregnant women up to 200% FPL as part of its 1115 waiver expansions. As a result of this expansion, Healthy Start, a state-only benefits program administered by BFCH that offers financial coverage for prenatal and postpartum care for income-eligibility women (up to 200% FPL) not eligible for MassHealth, increased its own eligibility criteria to 225% FPL. Healthy Start also offers telephone follow-up to assist in completion of the MassHealth application and information and referral about other prenatal and community support services to any pregnant woman who calls the statewide toll-free telephone line.

DMA has worked extensively to increase outreach and education to target populations and to facilitate the enrollment process. BFCH and other agencies have collaborated in a statewide effort to increase MassHealth enrollment: 1). A single, simplified benefits application, known as the Medical Benefits Request (MBR) form that includes all DMA MassHealth programs and CMSP, was implemented. DMA's computerized processing system automatically selects the most comprehensive benefits coverage for which the child or family is eligible and transfers the application to DPH for CMSP coverage if they are not eligible for any MassHealth coverage. MBRs may be completed and sent by mail. 2). DMA and BFCH jointly developed and funded a continuing statewide mini-grant program that funds fifty community health and service agencies to conduct locally designed outreach and enrollment assistance for families. 3). DMA has out-stationed staff who offer assistance in completing the MBR at 140 health and human service locations statewide. 4). DMA and the BFCH School Health Services Unit have worked closely with school systems and school nurses statewide as valuable resources to identify eligible families and assist with enrollment.

As a result of these and other⁸ eligibility expansions and enrollment efforts, MassHealth enrollment has increased from about 687,000 in FY1997 to an estimated 907,000 in FY2000, about 15% of the Commonwealth's total population of the Commonwealth. At the end of 1999, there were 397,825⁹ children enrolled in a MassHealth program, an increase of 30%, since July, 1997. Of the additional 91,362 children, 56% (51,173) were newly eligible through CHIP, 5.5% were newly eligible due to the 1115 waiver, and 38.5% were eligible under existing MassHealth eligibility requirements. Enrollment efforts have been very successful - the Massachusetts state plan had originally estimated only 37,100 CHIP-eligible children at full enrollment.

The Uncompensated Care Pool has benefited from the increases in MassHealth enrollment, as well as from the restructuring of funding sources required by 1997 Uncompensated Care Pool Reform Act

⁸ MassHealth eligibility for long-term unemployed adults without dependent children was also expanded.

⁹ This is a 'snapshot' enrollment as of 12/31/99. There were a total of 428,143 children enrolled at any time during FY99.

and the strong economy. While it had a \$157 million deficit in 1996 before the reform act and MassHealth expansion, it had an estimated \$9 million surplus in 1998. The Pool continues to be available to fund free care provided to uninsured low-income residents at acute hospitals and community health centers across the Commonwealth. As part of the Reform Act, these health care sites are now required to use a standard application form, to screen individuals for eligibility for MassHealth and other financial assistance programs, and to assist them in applying if appropriate.

Because of the growing availability of financial coverage for large portions of the MCH population, BFCH has incorporated stringent requirements into all contracted direct health care and enabling services programs that these resources be made available to families and billed before any MDPH funding: 1). All contracted providers must be participating providers in MassHealth, Healthy Start, and CMSP. 2). All clients must be screened for MassHealth, Healthy Start, CMSP and other relevant payer eligibility (e.g., uncompensated care pool), assisted with enrollment as appropriate, and 3). Providers must bill insurers directly for services to the full extent of coverage before billing MDPH.

BFCH programs, including WIC, MCH home visiting, SBHCs, family planning, MCH combined primary care programs, and EI, have each worked consistently to implement monitoring procedures to ensure that these policies are followed.

There are several important caveats to the Commonwealth's successful efforts to improve financial and actual access to care for MCH populations: 1). Many eligible individuals and families still do not successfully enroll in MassHealth. Many factors create potential barriers: erroneous knowledge about eligibility criteria, loss of coverage when transitional assistance ends, negative opinions about being a "Medicaid patient", reluctance to give a government agency personal information related to immigration issues or other reasons, or bureaucratic obstacles, or simply disorganized lives are all possible factors. The BFCH continues to monitor barriers through its Family Resource Line and to collaborate with DMA in identifying and reducing barriers. 2). Families of CSHCN continue to report barriers regarding insurance affordability, particularly with high deductibles, and extent of coverage for needed services such as speech and occupational therapy. In a recent survey of these parents attending a Family TIES conference, 12% of respondents cited concerns about insurance and affordability of care.

Managed Care

Medicaid Managed Care: MassHealth began moving toward managed care in 1991 with its first HCFA 1915b waiver and continued to expand this system as it implemented its 1115 waiver and CHIP. By 1998 most children and pregnant women covered by MassHealth, including SSI recipients, were enrolled in a managed care program. (The exceptions are CommonHealth, for which managed care

enrollment is optional, the MassHealth Family Premium Assistance Program, and children and youth in the custody of DSS or DYS).

DMA's managed care program is very well integrated into the overall health care delivery system in the Commonwealth through two different managed care program types. Approximately 77% of managed care members are enrolled in the Primary Care Clinician (PCC) Program, a fee-for-service gatekeeper model administered directly by DMA. There are 1,774 participating medical sites, including group practices, individual physicians, CHCs and hospital OPDs. A total of 1089 sites offer pediatric care and 282 offer obstetrics-gynecology¹⁰. Medical providers caring for patients enrolled in this model are reimbursed on a fee-for-service basis with an add-on case management fee. They are responsible to approval referrals to specialists, ERs, etc. Approximately 23% of managed care members are enrolled in one of 4 Managed Care Organizations (MCOs) with which DMA contracts to provide services on a capitated risk basis. (About 35% of MassHealth members are not in managed care, but DMA estimates that the percentage of children is much lower). Members are encouraged to make a specific choice of which PCC or MCO they would like to join, and adolescents are allowed to choose their own provider separate from their siblings and parents.

DMA reports that even with the significant increase in enrollment, there is an adequate supply of MassHealth primary care providers across the state, based on monitoring surplus capacity and indicators such as percentage of practices open to new MassHealth patients. The willingness of medical providers to participate in the MassHealth program is attributable to MassHealth's significant market share, relatively adequate ambulatory care reimbursement rates and successful ongoing efforts to work collaboratively with providers in addressing administrative and other concerns.

MassHealth's managed care implementation has generally not affected access or quality of services for CSHCN. With the right to choose between an MCO and a wide range of PCCs, most families have found that they are able to select a provider of their choice. (In some instances, families with private health insurance enrolled in MCOs have had more difficulties retaining their providers than have MassHealth families). The MCHB-funded Managed Care Enhanced Project jointly administered by the Division for Special Health Needs and DMA in the mid-1990s provided significant data that has been useful to efforts to identify how to help families of CSHCN to receive needed services in a managed care environment.

There is not current data regarding adequacy of linguistically appropriate services for MassHealth members. DMA does attempt to assign members to PCCs that report appropriate language capacity, but

¹⁰ OB-gyn providers may be MassHealth providers without becoming PCCs. Pregnant women may choose a PCC/ob-gyn or have another PCC and go to a participating MassHealth ob provider as a specialty referral.

this database is not always current. DMA is currently assessing the needs of members requiring services in languages other than English, and will be developing a report on their findings.

Specialists enroll with MassHealth separately from primary care providers (some sub-specialists may also be registered as primary care providers). There do not appear to be significant shortages of specialists available to CSHCN, although some families do report needing to travel to Boston from other parts of the state to receive needed services.

The significant exceptions to the general adequacy of MassHealth providers are a crisis-level shortage of participating dentists (see section on Oral Health Services below for more extensive discussion), and home health care. Massachusetts' home health agencies have been severely affected by the industry crisis precipitated by draconian Medicare cuts implemented as part of the Balanced Budget Act of 1997. At least 20 of 175 home health agencies in Massachusetts have ceased operations since 1998, and many others have had severe staff reductions. Families of CSHCN have felt the impact of these cutbacks, as there are fewer available services for Medicaid-covered children as well as those with Medicare. A survey of families enrolled in case management through the BFCH Division for Special Health Care Needs found that statewide an average of 23% of scheduled hours for approved home-based caretaking and nursing providers are going unfilled, with up to 37% unfilled in the central region. A survey of home health agencies providing pediatric care found a wide variation in number of requested service hours uncovered, but it ranged up to 28% in Boston and 46% in the central region.

Growing concerns about the managed care system: Massachusetts has one of the highest penetrations of managed care in the nation. Approximately 60% of insured residents, including most MassHealth members, are enrolled in some type of managed care plan. The market continues to be dominated by not-for-profit organizations (there is only one for-profit HMO in the state), and several of the largest HMOs consistently rank highly in national consumer satisfaction ratings and on HEDIS measurements.

Even as these are clear positive measures of Massachusetts HMO performance, many state residents, providers and legislators have expressed growing concern about issues with quality of and access to care in managed care organizations and of the long-term financial stability of some HMOs. These concerns were brought to the forefront in January 2000 when Harvard Pilgrim Health Care (HPHC), the largest HMO in the state with 1 million members, was put into state receivership after disclosing major downward revisions to its financial statements that called into question its ability to continue as a going concern. After months of questions about HPHC's future and a restructuring plan overseen by the state Attorney General and Insurance Commission, the state court approved a plan in May that allowed HPHC to come out of receivership and continue as an autonomous organization.

Meanwhile, there are concerns that other large HMOs, while not in financial crisis, are suffering increased operating losses due to holding down premiums for several years while they attempted to increase their market share at the same time that their medical and administrative expenses grew. The biggest HMO in western Massachusetts withdrew its entire Massachusetts presence in 1999.

While HPHC's near-disaster and the financial concerns of other HMOs have focused increased attention on managed care oversight, Massachusetts continues to lag in many of the legal requirements and consumer protections in managed care that many other states have implemented. Although a Managed Care Ombudsman Office was created by Executive Order of the Governor in 1998, it lacks regulatory authority. Currently a managed care reform bill is in conference committee, having been passed by both house and senate but with significant differences: prospects for its passage before the end of the current session in July 2000 are unclear. Both versions include provisions for consumer protection issues, include allowing a 'prudent layperson' approach to paying for emergency room care and ensuring 'medically necessary' care is covered, and for increased state regulation and review of HMO finances and operations.

Concerns about financial stability of "safety net" health care network:

The Boston area is well known for its excellent teaching and research hospitals and for its extensive network of community health centers (CHCs) that provide care to underserved clients. Yet in Boston and across the state, many hospitals and CHCs are facing increasingly difficult financial situations.

Hospitals have responded to increasing cost pressures over the past decade through multiple strategies. They have reduced bed capacity to the extent that Massachusetts has gone from being significantly overbedded to, in the opinion of some analysts, being in danger of having too few beds to meet future demand. Inpatient days and ALOS have been significantly reduced. There has been significant consolidation of hospitals into larger health care systems that have resulted in conversion of many hospital campuses to sub-acute or ambulatory care only.

Hospitals now report that they are in crisis as they struggle with health care insurers not covering the full costs of services on multiple fronts. MCOs have driven hard bargains for low contractual rates. In addition, MCO payment delays and high denial rates impacted hospital cash flow adversely. Hospitals state that MassHealth payments cover only about 80% of their Medicaid costs. Cuts in Medicare reimbursement as a result of the Balanced Budget Act accelerated destabilization, since Medicare is the major payor for inpatient hospital care statewide. The Massachusetts Hospital Association (MHA) estimated that Medicare cuts would in reduced revenue to Mass hospitals of \$1.7 billion over its first five years. According to the MHA, average hospital operating margins declined to negative numbers in FY98

and went down to negative 3% in FY99. The MHA has asked the state legislature to add up to \$100 million to Medicaid payments to hospitals, while the Governor has proposed an additional \$10 million.

Children's Hospital, the largest provider of MassHealth-reimbursed children's care in the state and a major regional provider for CSHCN, lost \$61 million in FY99 and has been evaluating which services to reduce or discontinue based on a breakeven analysis. In 1999 it closed an ambulatory dental clinic in a satellite health center serving high proportions of low income Hispanic patients and, according to published reports, it is re-evaluating its outpatient psychiatric services. It has requested increased rates from DMA to cover its costs, but DMA contends that it should not be covering the higher cost of providing many routine visits and procedures in a tertiary hospital setting and that many children should be redirected to other community resources.

While access to specialty services for CSHCN and perinatal services has not been affected by hospitals' financial crisis to date, there is a need to continue monitoring availability of these services. One concern is the potential of provider organizations in the tightening health care market using MDPH funds to supplant laid-off discharge planners, social workers, and other staff who perform enabling functions. While MDPH contracts contain a general proviso that funds should not be used for these purposes, more specific language and monitoring may be needed in the future.

As discussed in detail above, CHCs are a major public health presence in their communities, as they receive funding from MDPH to implement a variety of prevention and primary care programs. Most also receive funding from a variety of other sources, including their local hospitals, foundations, and other public sources. However, CHCs have experience increasing financial instability in recent years as they have seen their costs increase significantly and their operating margins decline. This has been due to a combination of factors, including the infrastructure costs necessary to operate in a complex managed care environment and increased personnel costs due to the state's strong economy and competitive health care market. One of the largest CHCs in the nation, which is a large provider of MCH services in Boston, was forced to declare bankruptcy in 1998 and was in court receivership for more than a year. At least six other CHCs have faced serious financial crises in the same period. In partial response to this situation, the state legislature approved \$5 million in FY2000 for additional funding to support infrastructure development in CHCs. This funding is being administered by the BFCH Division of MCFH.

Other Access to Care Issues

Cultural Competency of Services: The BFCH Office of Immigrants and Refugees (OIR) estimates, based on information from knowledgeable community sources in areas with significant newcomer populations, that the overall numbers of immigrants and refugees may be as high as 1.3 million, significantly higher than the 750,000 officially recorded (1990 census).

The OIR publishes an annual report documenting common health needs, medical practices and barriers to access for nineteen distinct immigrant populations in the Commonwealth. Issues may vary depending on the reason for immigration. Populations of newcomers from countries in upheaval due to war, persecution, they may suffer from post-traumatic stress syndrome or other mental health problems but not have the resources to receive needed help. Those coming for economic reasons may suffer from poor health status and have basic unmet health needs. Barriers to care may include inability to speak or read English, lack of understanding of the western health system, cultural taboos against receiving help for certain issues, such as psychiatric problems and domestic violence, and fear of giving personal information to government or other agencies to receive financial benefits, such as MassHealth or WIC, particularly for undocumented immigrants.

The restrictions created by the 1996 federal welfare and immigration reforms have further contributed to the reluctance of many immigrants to seek public sector services. Immigrants are aware that the designation of being a 'public charge' can lead to denial of permanent residency, inability to return to the US after a visit to their homeland, or even deportation. (The 1999 proposed rule that clarifies what public benefits non-citizens can receive without being designated by the INS as a public charge is a positive step). Restrictions on non-citizens receiving certain federal benefits have also caused confusion about applying for state-only benefits that are not restricted. Massachusetts' extensive network of community agencies and advocacy groups have worked hard, along with state partners that fund many of their efforts and direct BFCH outreach efforts such as the Health Access Unit Family Resource Line, to encourage immigrants and refugees to apply for the range of benefits that they may need.

Language barriers are almost universal for new immigrants. Spanish is the most common language spoken among immigrants, followed by Portuguese, Khmer, Chinese, Vietnamese, and Russian. In response to issues relating to language barriers in seeking emergency care, the state legislature passed the Emergency Room Interpreter Bill in April 2000, which will require competent interpreter service in the delivery of emergency health and mental health care as of July 2001. The Department of Public Health requires as a condition of contract that vendor agencies provide culturally appropriate services, and requests information related to language capacity of staff as part of every RFR. The Division of Medical Assistance (DMA) collects information on primary language as part of its application process and makes an effort to match each member language need with a provider with this capacity.

The ethnic and linguistic diversity of Massachusetts is dramatically portrayed in Figure 5.3.8-23, which displays the almost 40 ethnic groups that are part of the Healthy Start program.

The BFCH publishes all its educational materials in English and Spanish, and attempts to publish all smaller materials in at least the four next most common languages

Despite BFCH efforts, significant language and cultural barriers remain to effective service delivery to refugee and immigrant populations. As case in point is the area of domestic violence prevention and intervention. The Governor's Commission on Domestic Violence, staffed by the BFCH Violence Prevention Unit, was concerned by the disproportionate representation of immigrants among victims of domestic violence. In 1997 and 1998, its Subcommittee on Immigrant and Refugees, held hearing across the state to further assess the extent of need and barriers to service among newcomer populations. They found that despite aggressive statewide outreach about domestic violence, their messages had not effectively reached refugee and immigrant communities. Traditional beliefs and practices around marriage and gender roles, lack of understanding about victims' rights under the law, fear of immigration consequences, as well as language and other cultural barriers, contribute to the communication and service gap. Across all newcomer populations, representatives and advocates reported barriers encountered by insufficient interpreters and bilingual/bicultural staff in courts, hospitals, and the human services system. For newcomers who sought services, it was common to experience cultural insensitivity that resulted in effective denial of services.

The Domestic Violence Unit has responded to the findings and recommendations of the Governor's Commission by developing a unique new model of technical assistance contracts. Sixteen community-based organizations with expertise in particular newcomer populations have been funded to partner with the network of domestic violence programs in their communities to jointly share their knowledge and do more effective outreach.

The findings of these hearings regarding language and cultural barriers are not unique to domestic violence for newcomers seeking services. Spanish and Portuguese speaking parents of children with special health care needs responding to a BFCH needs assessment survey reported lack of staff who speak as a common barrier in seeking services for their children and a lack of translated materials.

Flexibility of Services: Interviews, surveys, and focus groups with parents and MCH service program participants repeated stress the need for greater flexibility in service availability. This seems to be a critical factor in keeping individuals involved and getting potentially eligible families enrolled. Current WIC participants, for example, are more satisfied with traditional office hours, but when former WIC participants and non-participating eligibles were asked, the vast majority have a need for evening and Saturday hours. Now that more families are working, flexible office hours have become even more critical. (WIC has recently mandated that all local programs have some evening and Saturday hours.) This is also evident in the FOR Families program which utilizes a variable hour schedule to contact families and conduct home visits with many contacts occurring not during traditional 9-5 Monday - Friday work hours. Other traditional barriers to service access continue to be a challenge for

Massachusetts families, including transportation. This is especially problematic in the more rural areas of the state, with the relative isolation of many residents. The Rural Health Workgroup reported that among rural parents and providers, a frequently heard frustration is that most services are based in the cities with the expectation that rural people will go to them, but that this expectation contradicts the reality of rural families' lives.

Welfare Reform

Implementation of Massachusetts' welfare reform initiatives predated the 1998 federal Transitional Aid for Needy Families (TANF) law due to the approval of a federal waiver and supporting state legislation in 1995. In October 1995 the state Division of Transitional Assistance (DTA) instituted several new requirements:

- In order to receive benefits, teen parents had to comply with certain provisions for remaining in school and living in an approved setting, either with their family or in a DTA-funded teen living center.
- For all recipients, DTA imposed a 'family cap' so that cash benefits were not available to children born while the mother was receiving welfare benefits, although these children are eligible for MassHealth (Medicaid) and food stamps.
- TANF recipients with children over age 6 years old were required to work for a minimum of 20 hours per week, which could not include education and training time.
- A time limit of 24 months in any five-year period was set on cash benefit assistance, with the first families coming off TANF due to time limits in December 1998. (Teens are exempt from time limits but must comply with other provisions to stay enrolled; some other categories of recipients, such as families with a child on SSI and domestic violence victims, are also exempt from time limits).

Since DTA began implementation of these reform measures, the welfare caseload has dramatically declined to its lowest levels since the late 1960s. In April 2000, the 43,814 families receiving cash assistance represented a decline of 56.6% since the passage of the state welfare reform law in February 1995. In the current caseload, approximately 27% of families are subject to the 24-month time limit: the remaining 73% are exempt due to their individual circumstances. Only 7% of the caseload is required to meet the work requirements –others are exempt because their youngest child is less than six years old, or for other reasons.

Most families that have left welfare in the past five years have not been terminated due to reaching the 24-month limit – they have left voluntarily. Since December 1998, 4,400 families have had cash benefits terminated due to time limits and approximately 75% of these have been referred to FOR Families. However, there is controversy about the extent to which these dramatic caseload declines

represent the success or failure of welfare reform. Some advocates argue that many families have simply left welfare ahead of being terminated, without adequate employment and other resources in place, and that those who have jobs have marginal employment with poor retention.

The FOR Families Program is beginning to accumulate data about the status of former TANF families it serves. While these data are a part of a tracking system rather than a formal evaluation, certain trends are emerging. Many families stabilize over time, but housing insecurity remains a major issue for a large percentage of them. A small number of families have a complex array of problems that put them at continued high risk – past and/or present domestic violence, substance abuse and mental health problems.

Former TANF recipients, whether they leave voluntarily or due to time limits, still qualify for a range of non-cash benefits, including MassHealth, food stamps, child care support, transportation subsidies, and employment assistance. Those who leave due to time limits and teens who are discontinued due to noncompliance with DTA procedures are eligible for home visiting and information and referral services through For Families, a unique program funded by DTA and administered by BFCH. Nursing and social service staff provide assessment of eligibility for the range of services that families are eligible for and provide assistance in retaining, re-certifying for or obtaining these services.

Homelessness and food pantry use have been rising steadily in the state even in the face of the record high employment rates. It is generally acknowledged that steeply rising housing costs are a downside to the strong economy that have disproportionately affected low-income and working class families. Massachusetts has the third highest overall housing costs in the country. Vacancy rates for apartments in many cities are running at less than 3%, contributing to rising rental fees. The Urban Institute reports that 39% of Massachusetts' families report difficulty paying their mortgage, rent and utility bills compared to 28% nationally. For Families data shows that housing assistance is the most common reason that time-limited families are referred to them, followed by food insecurity.

Project Bread, an umbrella organization that supports food pantries, soup kitchens and related hunger relief efforts in Massachusetts, reports that the use of food pantries by families is rising, and that their hotline answered nearly 35,000 calls last year from people about finding resources to help feed their families. Many food pantries attribute this apparent rise in food insecurity to the trade-off that families are making between housing costs and food, and some report anecdotally that a high number of their participants are former TANF recipients. At the same time, a recent USDA study reports that Massachusetts has 6.3% of families reporting food insecurity, which is the second lowest rate of food insecurity in the nation.

One apparent trend that is cause for concern is that food stamp participation has been declining significantly along with TANF cash assistance, although former TANF families are still eligible for food

stamps. The number of families receiving food stamps declined 45% from 1994 through 1999, a decline of about 200,000 individuals, many of whom are children. DTA conducted a survey of former food stamp recipients that showed that 41% appeared to still qualify for food stamps. Nearly one half reported that they believed they were no longer eligible. DTA has responded by developing new outreach initiatives to inform former welfare recipients of the eligibility criteria. The BFCH FOR Families program has been tracking food stamp participation for former TANF recipients who left due to time limits. The percent of them who re-certify for food stamps has risen from 16% to 38% over a six-month period.

There are 2661 teen families on the current caseload, 6.4% of the total. DTA and advocates are most concerned about families headed by teens who lose their benefits due to non-compliance with the DTA requirements for school and living arrangements. Many of these teens are presumably unconnected to health and social services, and they and their children are presumably at greater risk. In FY00, For Families began assuming teens in its caseload for the first time, with an emphasis on this high-risk group. About half of the 1100 teens referred to For Families had closed DTA cases due to non-compliance. About half of these have been located and assessed. Many have complex life situations including unsafe families and/or fractured extended family relations, domestic violence, substance abuse and mental health problems. The rest left voluntarily

Since the passage of federal welfare reform in 1996, the number of children under age 18 on SSI has decreased to 15,600 in 1999 from a prior high of almost 17,000. While the passage of welfare reform may have had an impact, it has also been a time of strong economic growth, which may have raised many families above the SSI income threshold. The BFCH Division for Special Health Needs employs a Public Benefits Specialist who supplies providers and consumers with current information on the complex system of benefits, including SSI, that are available for families of CSHCN. This service, which includes a toll free hotline as well as training and technical assistance, contributes to assuring that all SSI-eligible children are enrolled.

Mental/Behavioral Health Services

The Department of Mental Health (DMH), a sister agency to DPH within the Executive Office of Health and Human Services, has primary responsibility for mental health services in the state. For children and adolescents (and for adults), DMH's mission is to provide a continuum of services for individuals with serious mental illness or severe emotional disturbance. DMH has segmented its service provision so that it contracts through Division of Medical Assistance, the state Medicaid agency with a private firm (Behavioral Health Partnership) to provide population-based crisis assessment, intervention, and acute inpatient/outpatient services. DMH retains direct responsibility for 'continuing care' services

for those children and adolescents who meet the criteria of severe emotional disturbance. Continuing care includes case management, clinical support, longer-term hospitalization, residential and day program treatment, and community support services, such as respite care. While DMH manages the overall continuing care system, the majority of direct services are provided by contracted vendor agencies.

DMH provides services to only a fraction of those who have severe emotional disturbances. For example, more than 2000 children are on the waiting list for its case management services. The agency's limited financial resources impact its ability to provide sufficient capacity of services for children and youth with severe emotional disturbances. Acute inpatient pediatric psychiatry beds are filled (Children's Hospital in Boston runs at 100% capacity for its 18-inpatient beds) in part because children who should be discharged to longer-term residential cannot be placed. (DMA is certifying new acute pediatric beds, which should alleviate the situation somewhat.

DMH identifies other major concerns for children and youth as the lack of respite care programs, and general workforce shortages - for respite and residential paraprofessionals, mental health counselors and child psychiatrists. For youths from other cultures and who do not speak English, linguistically and culturally appropriate services are severely limited.

The need for increased resources to deal with mental health issues has been a growing concern voiced by stakeholders in BFCH programs. For example, the For Families program has identified mental health as one of the major needs of the former TANF recipients to whom it provides services. MaxCare recently co-sponsored a regional conference focusing on how early childhood providers can better manage and refer children with behavioral disorders in their programs. The Emergency Medical Services for Children Project recently identified the unavailability of acute psychiatric beds as being a major problem in pediatric emergency departments because they are unable to triage children sent to them with emotional or behavioral disorders into appropriate services.

With its mandate focused on individual services for children and youth with the most severe mental health problems, DMH does not have a systems approach to prevention of mental illness or early intervention. While many BFCH programs have addressed environmental risk factors associated with mental illness, such as child abuse and neglect, there has not been a Bureau-wide approach to collaboration with DMH and other stakeholders, data collection and program development that explicitly promotes mental health. Systematic linkages between community based programs and DMH services are limited.

DMH is both a provider and payor of last resort for mental health services. However, coverage in the private insurance sector has been very limited. While many managed care organizations in the state pay for prescription psychiatric medications, coverage for actual service delivery - both inpatient and outpatient- has been limited to the \$500 minimum required by state law. This situation should improve

substantially with the passage of a state mental health parity bill in April 2000 which is scheduled to take effect in January 2001. By requiring that insurance coverage for mental illness be comparable to that for physical illness, the law should increase access to care for many insured children and youth (ERISA-exempt plans do not have to comply). There is concern that this long-needed recognition of treatment needs for mental illness will place increased pressure on an already overtaxed mental health system. The BFCH recognizes a role for itself in monitoring referrals and areas of need for children and youth in its contracted programs.

Oral Health Services

Like medical primary care services, dental services for the maternal and child health population are provided largely at private dental offices and safety net providers such as CHCs and hospital OPDs. The BFCH Office of Oral Health (OOH), which administers public oral health programs for the Commonwealth, does not directly provide any services. It does, however, fund a program to provide dental care for developmentally disabled children and adults at six sites across the state through the Tufts Dental Facilities.

Although data on dental providers has certain limitations, it does not appear that there is an overall shortage of dentists. An estimated 4692 dentists have clinical practices in 6065 office locations. The overall ratio of one dentist for every 1304 dentists is higher than the national average. However, similar to medical services, the distribution of dentists is uneven, with a significantly higher concentration of dentists in the eastern third of the state. An estimated eighty communities lack any dentist. Figure 5.3.8-24 in Supporting Document 5.3.8 is a map that shows that these communities - and additional communities with dentists but none who accept MassHealth - are predominantly in the western and central thirds of the state. Many of these are also the communities without community water fluoridation.

With recent Medicaid expansions (discussed above), the MassHealth Program is now the insurer for almost 15% of the Massachusetts population. MassHealth provides dental care through provider agreements with community dentists and with safety net providers. While its dental benefit package for children is comprehensive, DMA's dental provider network has been rapidly declining in recent years, making actual access to care severely limited in many areas of the state.

Dental care has not been included in DMA's managed care initiatives – the agency still reimburses dental services on a fee-for-service basis and expects dentists to serve all MassHealth members who request care. The dental fee schedule has not been raised to keep pace with rising costs, and current reimbursement rates do not even cover the fixed practice costs for a patient visit. As increasing numbers of dentists have stopped participating due to low reimbursement, those left as MassHealth providers face overwhelming demand to serve patients that they feel unable to meet, leading

to further dentist disenrollment. In many Massachusetts communities today, it is impossible for MassHealth members to receive dental services without travelling long distances and facing long waits for appointments.

The 1999 Special Legislative Commission on Oral Health identified this deepening crisis in access to dental care for MassHealth as its major finding and recommended immediate increases to DMA's budget so that dental fees could be raised. Legislation currently pending in the state to increase the MassHealth budget by \$30 million for this purpose. Health Care for All, a statewide health care consumer advocacy group, has recently filed suit against DMA, charging that it in effect denies dental care to its members.

CSHCN have even more difficulty obtaining preventive and restorative dental services. MDPH assists in funding a program with 6 sites to provide services. However sites are not evenly distributed across the state, and their services are overtaxed due to a history of level funding even as need and costs have risen. There is presently a one -year wait for OR dental services, and they significant unmet have capital improvement needs. Since a majority of their clients are MassHealth members, the inadequate reimbursement as discussed above severely affects their overall financial viability.

The Office of Oral Health is presently compiling results of a questionnaire that was mailed with the 2000 dentist licensure renewals to ascertain which dentists have disability access, serve substantial numbers of disabled patients, offer a sliding fee scale, and offer services in languages other than English.

The BFCH has chosen as one its FY01 priority needs to 'improve oral health for children and youth, particularly those depending on publicly funded oral health coverage and those with special health care needs'.

3.1.2.4 Population-Based Services

Newborn Screening

The statewide Newborn Screening Program is administered by the MDPH Bureau of Laboratory Sciences in conjunction with the New England Newborn Screening Program at the University of Massachusetts. MDPH regulations require screening through a newborn blood sample for ten treatable disorders and

diseases¹¹ affecting newborns, including MCAD deficiency, which was added in 1999. All newborns must be screened unless the parents object on the basis of religious beliefs.

Also through the New England Newborn Screening Program, parents of all newborns are also offered the option of screening for cystic fibrosis and 19 other rare metabolic disorders. These optional screenings are offered as part of a research study focused on developing additional newborn screening protocols in the future.

The Newborn Screening Program has a standing advisory committee with representatives from pediatrics, neonatology, genetics, infectious disease as well as consumers, ethicists, and health care organizations.

A state law passed in 1998 (Chapter 243 of the Acts of 1998, An Act Requiring Hearing Screening of Newborns) mandates that a hearing screening be performed on every newborn in the state prior to discharge from a hospital or birth center, and that the MDPH promulgate regulations for newborn hearing screening. Over the past two years, the Universal Newborn Hearing Screening (UNHS) Program in the BFCH Division for Special Health Care Needs has been implementing this mandate. MDPH established a standing multi-disciplinary Advisory Committee to develop proposed regulations, which were approved this past year, and to advise on other aspects of program policy and implementation. Guidelines for hospital and birth center screening programs were developed and are now in use. The UNHS Program must approve individual hospital and birth center newborn hearing screening protocols. The UNHS Program provides payments for hearing screenings and diagnostic evaluations for newborns whose families are uninsured or underinsured through state funds.

The UNHS Program has received a HRSA grant to implement the Mass Hearing Linkage Project, which will ensure that each newborn who does not pass the hearing screening will have access to a medical home. Staff will perform outreach to affected families to ensure timely diagnostic audiological follow-up and access to Early Intervention services when a child is diagnosed with a hearing loss. Outreach will also be performed to the Massachusetts Chapter of the AAP and local pediatricians, health centers and other providers who serve newborns and young children with hearing loss.

The UNHS Program is collaborating with the Division of Vital Records to amend the electronic birth certificate (EBC) system to include the results of each newborn hearing screening. Information collected on the EBC will allow staff to document the number screened and begin tracking the newborns

¹¹ The ten conditions for which the Newborn Screening Program tests are congenital hypothyroidism, phenylketonuria, hemoglobin disorders, congenital toxoplasmosis, biotinidase deficiency, galactosemia, “maple syrup” urine disease, homocystinuria, congenital adrenal hyperplasia, and medium-chain acyl Co-A dehydrogenase deficiency

that miss or do not pass their hearing screening. The UNHS Program has also applied for a grant through the Centers for Disease Control and Prevention to enhance the ability to systematically track newborns.

FIRSTLink is MDPH's new statewide newborn screening and community referral program that uses the electronic birth certificate file to identify families with certain maternal or infant risk factors¹². See Figure 5.3.8-25 in Supporting Document 5.3.8 for a map of FIRSTLink births by community. FIRSTLink works with birth hospitals and birth centers to request all parents to sign an informed consent to participate. Consent information is entered into the electronic birth certificate system, which can be screened by the to identify families that have signed the consent form. Those families with identified risk factors are contacted by their local FIRSTLink Program and offered services. See Supporting Document 5.3.10 (BFCH: Overview and MCH Program Descriptions) for a more detailed description of FIRSTLink.

Lead Screening

The administration of statewide population-based lead screening and follow-up services are the responsibility of the Childhood Lead Poisoning Prevention Program (CLPPP) within the MDPH Bureau of Environmental Health. Its fundamental goals are identifying lead-poisoned children, ensuring that these children receive medical and environmental services, and preventing further cases of lead poisoning. The CLPPP provides a range of primary and secondary prevention programs. These include linkages with health professionals and other programs that provide services to children throughout the state, comprehensive and coordinated nursing case management for lead-poisoned children, public education about lead poisoning prevention and treatment, lead paint removal. The state Lead Law requires that all children between 9 and 48 months receive annual lead screenings. The CLPPP contracts with medical facilities statewide to provide lead poisoning treatment clinics.

Lead paint found in older housing is the most common source of lead poisoning. Massachusetts has the second greatest number of old homes in the nation, and has the highest number of old homes occupied by tenant families. The Lead Law requires the removal or covering of lead paint hazards in older homes (pre-1978) inhabited by children under 6. CLPPP promulgates standards for de-leading. Despite this prevalence, the percentage of tested children with elevated blood lead levels greater than 10 mcg/dL (5.6%) and greater than 20 mcg/dL (0.6%) have both declined significantly and are significantly lower than other states with high levels of older housing stock. (See Figure 5.3.8-26 in Supporting

¹² Infant screening criteria for FIRSTLink are birthweight \leq 1800 grams; SGA \leq 3rd percentile; 5 minute Apgar score \leq 5; abnormal conditions of the newborn; or congenital abnormalities. Maternal screening criteria are eligibility for Healthy Families (first-time teen parent home visiting program); parity high for age; inadequate or no prenatal care; alcohol use \geq 10 drinks per week; uncompensated care for delivery; or hepatitis B carrier.

Document 5.3.8 for map of communities still at high risk for childhood lead poisoning.) Massachusetts has the highest screening rate of any state, approximately 72% in 1998. For more information on the incidence of elevated lead levels, see Section 3.1.2.1.

Title V funds are used in CLPPP primarily to support community-based screening, medical case management, referrals, and family education and counseling in the highest risk areas of the state.

Immunization

Population-based immunization efforts and surveillance of vaccine-preventable diseases are the responsibility of the Massachusetts Immunization Program (MIP) within the MDPH Bureau of Communicable Disease Control.

The MIP is funded by the Centers for Disease Control and Prevention, with additional state funding primarily for the purchase and distribution of vaccines. The MIP funds several positions within BFCH related to training, outreach and technical assistance to contracted BFCH primary care, home visiting, and WIC programs as part of its immunization improvement initiatives. BFCH's specific linkages with MIP around the statewide immunization efforts are described in more detail below.

The MIP provides universal distribution of vaccine to all public and private providers for childhood vaccines, and certain adult vaccines. The focus of childhood immunization efforts statewide is to assure that immunization status is checked and vaccinations delivered at every possible opportunity within the context of primary care. Some local boards of health and home health agencies hold community-based immunization clinics, primarily for flu and pneumonia vaccination of adults, and in some cases have weekly or bi-monthly vaccination clinics for children. Several Community Health Network Area (CHNA) groups have made immunization improvement efforts the focus of their activities in the past five years, and have sponsored a number of activities to improve education and outreach regarding immunization. In addition, many communities throughout the state have sponsored school-based adolescent hepatitis catch-up immunization programs.

MDPH regulations require the full range of age-appropriate vaccines recommended by the ACIP for entry into licensed preschool/day care, schools, and post-secondary institutions.

The MIP recently suspended existing use and further implementation of the current version of the Massachusetts Immunization Information System (MIIS), a statewide electronic childhood immunization registry, due to technological limitations of the current system configuration. The MIP is continuing its strategic planning around implementation of a fully functional statewide immunization information system.

The MIP also conducts vaccine management audits and practice-based assessments of childhood immunization rates at public and private pediatric provider offices on an annual basis. These present an

opportunity for both assessment of actual rates and of modifications the practice can make to improve its rates.

The MIP collaborates closely with the statewide health care delivery system in its immunization improvement efforts. It funds an immunization coordinator position within the Massachusetts Chapter of the AAP.

BFCH has closely collaborated with the MIP in multiple aspects of statewide immunization improvement efforts. BFCH primary care, school health, WIC, and home visiting programs each have contract requirements for screening, education, and either provision or referral as appropriate. A MIP-funded MCH immunization program coordinator provides training and technical assistance to staff at BFCH-funded provider sites and had been working closely with MIP in the implementation of the immunization registry at BFCH-funded community health centers. The MIP also funds an Immunization Specialist position within BFCH to help support these activities. MaxCare, the BFCH safety and health in childcare program, has collaborated closely in a MIP Day Care Working Group, and has provided training on immunization requirements to childcare providers statewide. Growing Up Healthy, the child health diary developed by BFCH, contains a chapter on childhood immunization developed in collaboration with the MIP. The MIP-funded WIC Immunization Coordinator provides training, technical assistance and monitoring of all local WIC programs related to immunization. Local program staff perform immunization assessments at all infant and child certification and re-certification visits until a child has completed the primary series of shots.

SIDS and Bereavement Counseling

The Massachusetts Center for Sudden Infant Death Syndrome (SIDS), located at Boston Medical Center, is the statewide center for care and follow-up for bereaved families, professional training, and public education about SIDS. The primary objectives of the Center are to ascertain the cause of death in sudden infant mortality, notify parents of medical findings, and offer support to family members during their bereavement.

Services for families include 24 hour per day availability of telephone crisis counseling through a toll-free phone number, regular follow-up by community health nurses, support group meetings, and parent-to-parent support. Community health nurses include fluent speakers of Spanish, Haitian, French Creole, Portuguese and French. Monthly support groups are held in Boston, Worcester and Springfield and may be scheduled in other communities as the need arises. Telephone contact is made with all families whose infants die in hospital emergency rooms within 24-48 hours. The Center also develops and disseminates public education material regarding dealing with SIDS, grief literature and the reduction of risk factors, including promotion of the "Back to Sleep" campaign. In addition, the Center provides

training and technical assistance about SIDS to professionals in emergency medicine, emergency response, medical examiners' offices, public safety and social services.

Currently, the Massachusetts SIDS Center is expanding its services in order to provide culturally competent bereavement services statewide for families and significant others who have lost infants not only from SIDS, but from fetal demise, stillbirth, or other causes. The Center improves cultural competency among health care providers and service systems by addressing cross cultural grief responses and the development of appropriate interventions. The Massachusetts Center for SIDS is funded in part by BFCH through Title V funds.

Oral Health

Statewide oral health activities related to the prevention of oral diseases and conditions and improving oral health status are administered by the Office of Oral Health (OOH) within BFCH.

Community water fluoridation is a local community option. OOH provides technical assistance to communities regarding the benefits of fluoridation, assists in implementation efforts, and monitors fluoridated water supplies to assure concentration is within the appropriate range.

The OOH supports school-based fluoride mouthrinse programs for elementary schools in non-fluoridated communities by providing supplies, training, and technical assistance. A supplemental fluoride tablet program is made available for all HeadStart programs operating in non-fluoridated communities. These valuable programs currently reach only a fraction of eligible schools due to limited funding.

Until recently, the placement of dental sealants was almost entirely a function of private dental offices, with only one community in the state offering school-based services. A limiting factor in community-based sealant programs has been the state licensing requirement for dental hygienists that a dentist order is required for each individual sealant application. There is also limited data available on prevalence of sealants, with the best information coming from snapshot surveys in selected communities. OOH, in collaboration with the Massachusetts Coalition for Oral Health (a public-private statewide partnership) is currently implementing multiple dental sealant models for the delivery of preventive services to low-income and minority third graders. Beginning in FY01, the Office plans to demonstrate these models in an eight-site dental sealant program and has applied to the Delta Dental Foundation of Massachusetts for funding to implement the proposed project.

The OOH provides public and school-based education materials related to oral health promotion, proper dental hygiene, oral cancer, and dental injury prevention.

The OOH collaborates widely both within BFCH maternal and child health programs, with other MDPH Bureaus (e.g., HIV/AIDS) and with other state agencies, insurers, and community organizations to improve oral health status and access to oral health care.

For information on the oral health care service delivery system in Massachusetts, see sections 3.1.2.2 and 3.1.2.3 above.

The OOH and its programs are supported through state-only funding and Title V. The supplemental fluoride programs for schools and pre-schools are supported in part by Delta Dental Plan of Massachusetts.

Injury Prevention

Coordination of statewide public health initiatives for intentional and unintentional injury prevention is administered by the Injury Prevention and Control Program within the BFCH Division of Community Health Promotion. The Program oversees a broad range of childhood injury prevention activities that focus on education, training and technical assistance, and collaboration with both public and private partners to build statewide injury prevention infrastructure, data analysis and reporting. See Supporting Document 5.3.10 (BFCH: Overview and MCH Programs) for a detailed description of the services provided by the Injury Prevention and Control Program.

Nutrition

Statewide public health nutrition efforts are coordinated by the Nutrition and Physical Activity Initiative within the Health and Wellness Unit of the BFCH's Division of Community Health Promotion. In addition, the BFCH WIC Division is responsible for improving the nutritional status of its participating pregnant and breastfeeding women, infants, and children.

The Nutrition and Physical Activity Initiative promotes improvement in health status through a range of activities related to developing healthy eating habits, maintaining regular physical activity and reducing health risk factors. Initiatives are particularly targeted to high-risk, underserved and low-income populations.

The Coordinated Food Stamp Outreach Program is a statewide outreach program to increase awareness of the Food Stamp Program and to encourage families and individuals that meet its income guidelines to apply for participation. The program, which includes statewide activities coordinated with local and regionally based activities, is a public-private partnership of the MDPH, the Department of Transitional Assistance and Project Bread. A statewide toll-free information line provides confidential screening services for the food stamp program and referrals to other food resources.

The 5 A Day Program is designed to give a simple, positive message-eat 5 or more servings of fruits and vegetables every day for better health. MDPH coordinates 5 A Day activities and the state level through the Massachusetts 5 A Day Coalition, a working group of nutrition and health professionals.

The Folic Acid Campaign, a multimedia public education campaign to raise awareness of the importance of adequate intake of folic acid in reducing certain birth defects is coordinated through the Division of Special Needs.

The WIC program is designed to influence lifetime nutrition and health behaviors for its participating low-income women, infants, and children by providing nutrition education and counseling, checks for nutritious foods, and other services. WIC provides statewide services through a network of contracted local programs. Each local program is responsible for conducting a nutrition assessment on all participants. Food packages specific to each family's need are prescribed that may be redeemed at a statewide network of participating stores. The WIC Program emphasizes breastfeeding as the optimal infant feeding method. WIC is funded through the U.S. Department of Agriculture with supplemental state funding

In addition to these efforts, several other BFCH programs support direct nutrition services to high-risk populations. 1). The Growth and Nutrition Program in the BFCH Division for Special Health Care Needs provides specialized multidisciplinary evaluation and treatment for children whose growth pattern poses a concern to parents or providers. The Program provides services through seven contracted tertiary care sites across the state. 2). The Combined Primary Care Program provides funding to 40 community health centers and other primary care sites statewide to enhance the support and health access services available to pregnant women, children and adolescents. The Program requires that all contracted vendors provide the services of a qualified nutritionist, and directly funds nutrition services in many sites. The pediatric/prenatal nutritionist based in the Nutrition and Physical Initiative provides guidance and technical assistance to health center staff and nutritionists on programming and accessing resources. The nutritionist also works collaboratively with the WIC to coordinate continuing education sessions for health center and WIC nutrition staff. 3). An Adolescent Nutrition and Health Promotion coordinator serves as a resource to both MDPH and other programs serving youth. The role of this position is to encourage integration of positive messages around nutrition and physical activity behaviors; to work with school personnel (educators, nurses, administrators, food service staff etc.) to encourage integration of appropriate nutrition and physical activity messages in the school environment; and to promote statewide dissemination and implementation of the "Healthy Choices Program", a school-based nutrition and physical activity program for middle schools.

The Bureau has identified the rising prevalence of childhood obesity as a priority area and is developing a cross-Bureau obesity initiative. WIC is seeking additional USDA-funding to enhance its

programmatic efforts to address obesity for participating children, birth to age five. BFCH is also developing an application for submission to the Centers for Disease Control and Prevention to address obesity in youth. The School Based Health Center Program has funded special projects to address community-specific priorities as part of its most recent procurement. Twelve operational SBHCs have been funded to develop nutrition or obesity programs for the next fiscal year.

Outreach/Public Education

Outreach and public education are integral parts of BFCH's core public health mission, and are incorporated into program implementation at many levels. These efforts are carried out directly by BFCH staff, through contracts specifically to carry out public media campaigns, and through contracted community vendors who are implementing BFCH programs.

Assessment of the needs for public education and decisions about the best manner in which to conduct them are based on the goals of the individual program or initiative. These may include television and radio messages, billboard campaigns, and dissemination of brochures and other printed materials. BFCH programs organize, support, and participate in public conferences and workshops targeted to specific populations. Several BFCH programs maintain public toll-free hotlines that offer information and referral related to individual services. These numbers are widely promulgated in other written materials.

Outreach to underserved target populations is key to reaching BFCH goals for population-based health improvement. All BFCH-funded community-based programs contain contract requirements related to outreach. For example, perinatal providers receiving Combined Primary Care Program funding must do outreach to pregnant women in their communities. Family Planning providers are required to do outreach and public education. Teen Challenge Fund providers utilize a wide array of outreach methods to reach 10-19 year olds to promote healthy lifestyles and pregnancy prevention. Early Intervention programs, which are required to do case-finding, visit childcare centers, parent groups, and other community sites to educate their communities about the availability of EI services.

In the past two years, BFCH has emphasized improving capacity to undertake effective public education through skill building in areas such as social marketing techniques.

School Health

The role of the BFCH School Health Services Unit in improving school health services has greatly increased in the past three years with the significant expansion of the Enhanced School Health Program. The School Health Services Unit now has 77 contracts to provide or develop enhanced school health services to 175 school districts. This has greatly enhanced BFCH's efforts to reach adolescents in a

population-based setting to provide health promotion, referral for services and to conduct surveillance. See Figure 5.3.8-26 in Supporting Document 5.3.8 for a map that displays all of the communities that are now reached through Enhanced School Health Services projects.

The School Health Services Unit also collaborates with other MDPH programs and the Massachusetts Department of Education to provide ongoing systems development and technical assistance to the Commonwealth's 351 public school systems, and more recently to the 600 private schools. These include standard setting for school health services, updating and monitoring mandates specific to school health, technical assistance and continuing education for school health personnel and promoting certification of school nurses and improved reimbursement for school health services.

3.1.2.5 Infrastructure Building Services

State-level Issues

The Bureau of Family and Community Health (BFCH), headed by the Title V administrator, already contains within its 'walls' many of the services that must coordinate in order to attain comprehensive systems of care. Services for children with special health care needs (CSHCN), WIC, Early Intervention and Ryan White Title IV services work collaboratively under the same organizational structure as other maternal, child, and adolescent health primary care and prevention initiatives. These include Children's Medical Security Plan, Healthy Start, School Health, MCH primary care and MCH home visiting. Other primary care and prevention programs that include MCH populations in their broader mandates, such as the Office of Rural Health, Primary Care Office, and State Loan Repayment Program, are also co-located within BFCH.

The co-placement of many related programs within BFCH facilitates opportunities for programs to collaborate in efforts that promote integrated, comprehensive approaches to care. The results of such collaborations are evident in the crosscutting nature of BFCH programs. Even within an organizational structure that facilitates integration, however, there are challenges to assure that opportunities are taken, and that the potential duplication of services to the same client population is addressed. Each program brings its own sets of federal and/or state funding and regulatory mandates to its implementation efforts. Designing systems that address categorical program requirements yet are 'user-friendly' at the community and individual participant level remains one of the greatest challenges.

Internal organizational structure, culture, and operational procedures can also impact collaborative processes. The BFCH is presently undergoing a strategic planning process to evaluate its mission and to identify opportunities for internal organizational improvements to best achieve its goals and objectives.

Within MDPH, MCH programs have multiple working partnerships with other Bureaus. For example, perinatal and adolescent health staff collaborate with the Bureau of Substance Abuse and the AIDS Bureau. The Family Planning Program collaborates closely with the STD program in the Bureau of Communicable Disease.

At a larger state agency level, there are multiple agencies concerned with the welfare of children and adolescents in particular that provide or fund services that target the same populations that BFCH programs serve. The state Executive Office of Health and Human Services (EOHHS) has given priority to addressing state level coordination of service delivery to assure that services are comprehensive, non-duplicative and easily accessible. All EOHHS agencies now have the same six service regions, a change that has facilitated cross-agency collaboration for some communities that formerly cut across different agencies' regions. The EOHHS Targeted Cities Initiative has identified eleven cities in which to develop a consolidated model of EOHHS agencies working with local government to streamline service linkages. This initiative is initially focused upon services to children, and BFCH is an active participant

Development of comprehensive service systems requires many levels of relationship with other state agencies. These range from participation in joint taskforces to interagency service agreements (ISAs) to deliver services to MCH populations on behalf of other state agencies. These relationships are fully listed in section 1.5.2 (State Agency Coordination).

An example of a major initiative to develop better state-level integration in a comprehensive system of care is an inter-agency planning effort through EOHHS directed toward children from birth to age five. EOHHS is working with all relevant state agencies and programs to coordinate policies and programs in developing, implementing and managing community based programs for infants and young children. This effort will focus on creating a seamless system of services for any individual child and family regardless of the funding source or agency responsible and will include a strong community level effort to ensure the development of a process that provides for identification, referral, coordination and information to the full range of services and supports available for families with young children.

Local-level Issues

Both within BFCH itself and within MDPH more broadly, the nature of the MDPH's community-based service delivery system presents both strengths and challenges. With few exceptions¹³, MDPH provides direct services through contracting with the private, not-for-profit health and human service delivery

¹³ Exceptions include the Family and Community Support Programs within the Division for Special Health Needs, which employs its own case managers and the For Families home visiting program for families transitioning off welfare.

system across the state. State regulations and good business practice mandate that contracting be done through competitive procurements (known as Requests for Responses, or RFRs), which must be periodically re-issued (most BFCH contracts are now issued for 5 - 9 years). Reliance on this competitive process results in service delivery being shaped by local organizations that are in the best position to understand the needs of their communities' target populations. MDPH gives preference in the procurement process to organizations that demonstrate community input into their governance. However, since in this delivery system MDPH does not directly control 'production' of services, many challenges arise.

The distribution and density of health and human service organizations across the state is variable, resulting in different configurations of agencies offering services. In some communities, for example, the WIC program is operated by a community health center in an integrated manner with its prenatal and pediatrics services, while in other communities a multi-service agency may administer the WIC program. There are communities in which MCH home visiting programs and Early Intervention are operated by the same agency, and other communities in which they are operated by separate agencies, which may see each other as competitors. There are instances in which MDPH has not been successful in finding an appropriate community bidder for a given service. On the other hand, there are communities where there are multiple potential agencies, and where service delivery may best be accomplished through a collaborative arrangement among multiple agencies. While there are multiple successful instances of such collaborations (for example, the Teen Challenge Fund requires such coalitions with a designated lead agency), local organizational and political issues sometimes come into play that forestall other potential collaborations that MDPH believes would better promote more efficient service delivery.

MDPH must also be concerned that organizations with which it contracts are stable, financially viable concerns and are carrying out the terms of their program contracts in good faith. MDPH has focused on improving its abilities and tools to proactively monitor organization-wide and contract-specific fiscal and operational requirements in the past three years, and continues to prioritize this effort. It has also developed initiatives to give training and technical assistance to small community-based organizations and their boards of directors to assist them to build capacity. Within the context of this larger MDPH initiative, BFCH has improved its own contract monitoring capacity and procedures and has developed structures for improved and more proactive inter-program communication about common contracting organizations. At the broader state level, BFCH has taken a leadership role in initiating an ongoing workgroup of EOHHS agencies that have fiscal relationships with common provider groups, such as community health centers, to enhance communication and coordination around technical assistance issues.

This mosaic of service programs in various agencies that BFCH and MDPH assist in creating and maintaining may look different in each community. While BFCH considers this community-specific flexibility to be a strength, it does have the potential to create barriers to easy access for targeted program participants. A key challenge is to create local collaborations and procedures that facilitate non-duplicative entry points for service for families. This challenge references back to Bureau-level efforts at program collaboration, in which BFCH program managers have worked to include contract requirements for local collaborations. The Bureau's goal is to deliver needed services to pregnant women, children and families with minimal redundancy in enrollment for services and optimal integration of service components delivered to families depending upon their needs, from high technology and specialty services to enrollment in health insurance, immunization, preventive visits, and safe child care.

Another challenge is creating an infrastructure for preventive and enabling services that are broadly available for targeted populations, regardless of where they receive their care. For example, most BFCH contracts and services are directed toward not-for profit health care organizations, such as CHCs and hospital OPDs. While these providers serve large numbers of high-risk patients, the majority of the MCH population statewide receives its care in private medical offices. While the wide availability of potential medical homes, even for low-income populations (enabled in large measure by the broad provider contracting of DMA's MassHealth Program) is an enormous system strength, current BFCH programs need to improve collaborations with private medical offices to assure linkages to enabling services.

The BFCH Division for Special Health Needs is revising its Family and Community Support Program to shift from a freestanding model to a model housed in a medical home. It plans to re-deploy community-based case managers to physician office and hospital clinics to be special care coordinators for all CSHCN in a given practice, and to provide technical assistance to a broader range of pediatric practices on meeting the needs of CSHCN and their families.

Systems and Collaborative Mechanisms for MCH Population Groups

See sections 3.1.2.2 and 3.1.2.3 for description and assessment of the delivery systems for the MCH population groups.

Coordination Efforts with Other Public Programs

- **Medicaid:** A comprehensive list of coordination initiatives with the Division of Medical Assistance (state Medicaid Agency) is included in section 1.5.2 (State Agency Coordination).
- **Supplemental Security Income Program:** The Division for Special Health Needs receives notification from SSA of all newly enrolled child SSI recipients. Families receive information from

the Department offering case management and family support. The Division also employs a Public Benefits Specialist who chairs a statewide SSI Networking Group and conducts continuing programs of training and technical assistance in the area of SSI and other public benefit programs for CSHCN.

- **Ryan White and Title IV AIDS Program:** The Division for Special Health Needs' MassCARE (Massachusetts Community AIDS Resource Enhancement) Program is a Ryan White Title IV-funded program to ensure comprehensive, family-centered, culturally and linguistically competent care for children, youth and families living with HIV. MassCARE is also charged with promotion of early identification and entry into care of women with HIV. A member of MassCARE's Family Advisory Network chairs the statewide AIDS Consumer Advisory Board.
- **Social Services Programs:** The BFCH collaborates at the state level with the Department of Social Services, the agency charged with protecting children from abuse and neglect. See section 1.5.2 (State Agency Coordination) for a complete list of these collaborative initiatives. The BFCH also collaborates with community-based social services agencies in many of its service programs.
- **Special Education Programs:** Within the BFCH Division for Special Health Needs, both the Family Community and Support Program (Case Management) and the contracted MASSTART Program work closely and directly with special education (SPED) programs at the local level, providing consultation to families and schools about inclusion of children with special health needs. The Division also funds two transition specialists at the Federation for Children with Special Needs who provide training and technical assistance to SPED programs about their responsibilities and about best practices in relation to transition. On a statewide basis, the Division works with the SPED leadership of DOE in the Early Intervention Interagency Coordinating Committee and the Massachusetts Partnership for Transition and is represented on the statewide SPED Parent Advisory Committee.
- **Early Intervention:** MDPH is the state agency charged with administering Massachusetts' Early Intervention Program under Part C of IDEA. The Early Intervention Program is in the BFCH's Division for Special Health Needs.
- **Vocational Rehabilitation Programs:** The Division for Special Health Needs works closely with the Massachusetts Rehabilitation Commission (MRC), the state agency charged with overseeing rehabilitation programs both in its adolescent transition programs (discussed below) and in relation to its focus on services for adults with disabilities.
- **Mental Health Programs:** BFCH has a close working relationship with the state Department of Mental Health (DMH), particularly with its Child and Adolescent Health Unit. BFCH and DMH have reciprocal representation on each agency's community advisory committees, and individual BFCH programs are increasingly coordinating with DMH. For example, the MaxCare Program

(Maximizing the Health and Safety of Children in Out-of-Home Care) recently co-sponsored a regional conference on linkages to mental health services for childcare centers in which DMH staff collaborated in planning and participating.

- **State interagency transition programs:** The Division for Special Health Needs convenes and staffs the Massachusetts Partnership for Transition, a statewide coordinating council aimed at supporting the transition of youth with disabilities to adulthood and adult service systems. The Massachusetts Rehabilitation Commission is consistently and actively represented on the Partnership for Transition.
- **Developmental Disabilities programs:** The BFCH Division for Special Health Needs collaborates with the state Developmental Disabilities (DD) Council on many committees and special projects. Additionally, it maintains close working relationship with and is represented on the advisory committees of the Shriver Center and the Institute for Community Inclusion (ICI), which are DD-focused university-affiliated programs in the state. It works closely with ICI in relation to adolescent transition and has contracted with ICI around development of materials for providers concerning transition. The BFCH Office of Oral Health provides funding for a contracted dental program to provide dental care to developmentally disabled children and adults in seven sites across the state, and coordinates with the DD Council to improve dental care for residents with DD.
- **SSDI:** The SSDI is administered by the BFCH Policy Office, which also has overall responsibility for the MCH block grant development.
- **School Health Programs:** The School Health Services Unit within the BFCH Division of Maternal, Child and Family Health collaborates with other MDPH programs and the Massachusetts Department of Education to provide ongoing systems development and technical assistance to the state's 351 public school systems and 600 private schools. This includes technical assistance and continuing education for school health personnel, including an ongoing School Health Institute. A comprehensive list of collaborations with DOE can be found in section 1.5.2 (State Agency Coordination).
- **WIC:** The Massachusetts WIC Program is administered as a division within the BFCH.

Coordination efforts with major providers of health and health-related services

BFCH has numerous initiatives that involve collaboration with children's hospitals and tertiary medical centers. For the Division for Special Health Needs, the foundation for close collaboration with specialty care is the ties that the case management program has with staff of those facilities. The Division outstations case management staff at five tertiary pediatric facilities across the state for several clinic sessions per month and does day-to-day collaboration on individual children's discharge plans. The MassCARE, MASSTART and Massachusetts Initiative for Youth with Disabilities Programs contract

with tertiary hospital-based clinics to carry out specific initiatives. The Division also works with specialty care providers on a variety of planning efforts. They are represented on advisory committees for newborn hearing screening and genetics planning, and are included in the Mass Partnership for Transition.

The MDPH Perinatal Advisory Committee, co-chaired by the Assistant Commissioner of BFCH (Title V Director) and the Director of the Division Health Care Quality in the Bureau of Health Quality Management, includes representation of medical staff from hospitals with high-risk obstetrics and Level 3 nurseries.

Coordination with Medical Associations

BFCH staff participate in the Massachusetts Chapter of the American Academy of Pediatrics (MAAP) monthly Pediatric Council meetings. A MAAP representative sits on the BFCH Community Advisory Committee and MAAP will be invited to participate in the new School Health Advisory Committee. Input from the MAAP is also sought on specific initiatives as appropriate. For example, MAAP representatives were actively involved in development of the Massachusetts Bright Futures Campaign, including development and review of *Growing up Healthy*, the Child Health Diary. The Division for Special Health Needs specifically has a close working relationship with the MAAP around many of its programs and initiatives. As an example, the proposed revision of the Family and Community Support Program (case management) to a Special Care Coordinator system has been developed with MAAP input.

The BFCH has recently strengthened its relationship with the Massachusetts Chapter of the American Academy of Family Physicians (MAAFP) through informal collaborations. A MAAFP representative will be invited to join the School Health Advisory Committee and the MDPH Perinatal Advisory Committee. BFCH staff attend regular meetings of the MAAFP Executive Committee.

BFCH has collaborative relationships with many obstetricians across the state. Representatives of the Massachusetts Chapter of the American College of Obstetrics and Gynecology (MACOG) are active members of the Perinatal Advisory Committee and the Maternal Mortality and Morbidity Review Committee. Obstetricians are consulted as required on other special initiatives, such as the development and review of *Growing Up Healthy*.

Coordination with Family and Parent Advocacy Organizations

The Federation for Children with Special Needs is a key collaborator and contractor with the Division for Special Health Needs. Parent consultants who work on many BFCH programs are hired through the Federation, which also serves as a support and mentoring function to newly hired parents. The Federation contracts with MDPH to provide information and federal services to parents the development of a web-

based data system and deployment of parent consultants as information providers in DPH regional offices. The Division also works closely with the Parent Advocacy League, an organization of parents of children with mental health needs, and with Families United for Change, an organization of parents whose children have developmental disabilities. One outcome of this broad collaboration is an annual parent conference of which MDPH is a co-sponsor. This year's conference drew more than 500 participants.

Constructs of a service system for CSHCN

Please refer to **ERP Form 13** (the degree to which the State has established appropriate services for CSHCN) in Supporting Document 5.8.

1. Although a long-term policy group comprised of leaders of child-serving agencies has been less active through FY 2000 than in the past, MDPH has continued to ensure collaboration with other agencies through specific initiatives that we oversee or in which we participate. Key among these collaborative efforts have been the Massachusetts Consortium for CSHCN, which includes both state agency and consumer and provider representatives; the EI Interagency Coordinating Committee, which has promoted strong interagency collaboration for the 0-3 population generally, the DMA/DPH Child and Adolescent Work Group, which meets regularly to identify and address shared priorities in relation to Medicaid enrolled children; and the Partnership for Transition, discussed above.
2. The contracting process has provided a mechanism to promote stronger awareness of and responsiveness to CSHCN needs at the community level. BFCH primary care contracts with community health centers and other primary care sites and enhanced school health contracts have also required specific attention to needs of CSHCN within community populations. Specific programs of the Division for Special Health Needs address the special needs of children with disabilities at the community level. Initiatives in this area include intensive efforts to promote provision of EI services in natural environments (aimed not only at improved services for individual children but also at increased community understanding of and capacity to meet special needs), the MASSTART program, which provides consultation to school systems and families about safe school placement of very medically involved children, and efforts of the Mass Initiative for Youth with Disabilities to promote and support recreational inclusion for CSHCN. Plans for out-stationing of case managers, described previously, also aim at increasing capacity of community-based providers to meet the medical needs of CSHCN.
3. Medicaid managed care has enhanced opportunities for coordination of care at the community level in Massachusetts. Unlike states in which families experience Medicaid managed care as a de facto cut in benefits, the Commonwealth has chosen to provide a choice for families between a traditional MCO

and membership in Medicaid's own PCC gatekeeper managed care program. While parents still frequently report fragmentation of care, this shift has enhanced coordination for parents of CSHCN. The Division of Special Health Needs' case management, while it operates outside the health care system as a freestanding program at present, also helps families coordinate among levels of care.

4. The Division of Special Health Needs' case management coordinates other services as well as health services at the community level. Case managers try to provide the 'glue', in the form of information, advocacy and support, that makes systems that are not necessarily coordinated more coherent to families.

Standards of Care, Program Effectiveness and Continuous Quality Improvement

Integral to all Bureau and Department program efforts is an emphasis on providing quality services that address specific health improvements for one or more identified MCH population group. There are some commonalities but also individual program variations in approaches to implementing standards and quality assurance. At the most prescribed end of the spectrum are regulatory approaches to standards, such as for newborn blood and hearing screening, which may be required by state law. Other programs develop detailed standards that are included in the contract scope of service or may be incorporated into contract monitoring tools. New programs may first develop more general guidelines that are codified with increasing experience. Some programs, such as Early Intervention and School Based Health Centers, pre-certify programs according to established standards before they can be eligible to apply for funding. In developing standards or guidelines, BFCH always seeks input from relevant stakeholders and experts to assure that current best practices are incorporated. Various methods are used for this process, again depending on the particular program or initiative.

Although approaches to standards and guidelines vary, all BFCH programs that contract for any type of service are required to follow standard Bureau and Department procedures for contract monitoring and performance review. BFCH has established a comprehensive process for the establishment of annual performance measures and benchmarks for each program, which correspond to the extent possible with national and state performance and measures for Title V.

Program effectiveness is also monitored by contractually defined requirements for periodic site visits by BFCH staff and periodic written narrative and/or data reports. In FY98 MDPH initiated a revised contract review process which incorporated the development of a uniform assessment form that incorporates multiple levels of information, including success on performance measures, site visit results, and fiscal and administrative contract compliance into its scoring.

Continuous quality improvement for each population group is monitored through assessing progress in meeting Title V state and national performance and outcome measures and additional process measures identified by individual programs.

Issues related to **monitoring the development of community-based service systems** are referenced in the discussions above.

3.2 Health Status Indicators

See **ERP Forms C1 - C3** for Core Health Status Indicators data.

See **ERP Forms D1 and D2** for Developmental Health Status Indicators data.

3.2.1 Priority Needs

Summary of the Needs Assessment

The overall health status and access to health care services of the MCH population in Massachusetts continues to improve in many areas. At the same time, however, there are some areas in which this generally positive progress has reached a plateau, or in which poorer outcomes have persisted. While improving overall, there continue to be significant disparities in outcomes and measures for some population groups. There are also some concerning trends, such as the growing number of very low birth weight births and the increasing perinatal mortality rate, that are confronting the state. These trends require further analysis and study to identify more clearly the underlying contributing factors and develop strategies for improvement. Because of wide and growing coverage of health services through MassHealth and CMSP, relatively little Title V funding is expended on direct services. Rather, BFCH efforts are primarily focused on enabling, infrastructure and population-based services to further improve accessibility and coordination of services.

Direct health care and enabling services: The health care delivery system in Massachusetts has been characterized by three major trends in the last half of the 1990s that have implications for providing accessible, quality services to infants, children, youth, and pregnant women:

- increased financial access to health services
- growing concerns about managed care from consumers, providers and legislators
- growing financial instability of the largely not-for-profit provider health care network.

Successful outreach and enrollment efforts have been collaborative initiatives of the BFCH and DMA (Medicaid). A steep rise in prenatal enrollments in Healthy Start needs to be monitored closely, and contributing factors identified. Financial access, however, is only the first step in assuring quality preventive services for mothers and children and children with special health care needs. Major resources have been directed toward assuring the availability of comprehensive, community based, culturally

competent services, with a strong network of safety net providers in the Community Health Centers and School Based Health Centers. A statewide system of care coordination, especially for CSHCN, does not exist, although there are many services, agencies and programs that are resources to families. Other barriers to access to health care and related services continue to be cited by parents and other consumers, including flexibility in hours services are offered, lack of transportation, lack of providers who speak a language other than English (especially in mental health), and often a lack of knowledge of what is available. A lack of accessible providers is an issue in oral health, with many areas with no pediatric dentists, dentists not participating in Medicaid, and dentists not willing or knowledgeable in the care of CSHCN.

Population based services: Virtually all newborns are screened for metabolic disorders, and a pilot project that offers screening for 19 additional disorders and cystic fibrosis is underway. Massachusetts has also made great progress in the numbers of newborns who have received hearing screenings prior to discharge from a birth center or hospital. It is expected that during fiscal year 2001, approximately 95% of all newborns will receive newborn hearing screenings. This is a significant achievement since the passage in 1998 of a state law providing for this service. School based health centers and enhanced school services are two other mechanisms for delivering population based services that have been expanding in recent years and are increasing in capacity.

Infrastructure building services: Collaboration and partnerships on the state and local levels have been historical and consistent priorities for the DPH. The establishment and growth in capacity of the Community Health Network Area Coalitions have brought new dimensions to this emphasis on partnerships. Numerous initiatives, programs, and new strategies and approaches to health and health systems issues have had successful impact as a result. Challenges remain, in particular with the coordination and integration of the services system for at risk children from birth to age 3, and improvements and strengthening of IT systems and data linkages to support efforts in all levels of the pyramid.

Priority Needs Selected

From its analysis of these findings, the Bureau of Family and Community Health selected the following 10 Priority Needs. Many of the areas identified by the needs assessment that resulted in the identified priorities cut across more than one level of the pyramid. The level(s) of the pyramid that each priority addresses, and the population group(s) covered by the priority, are cross-referenced on the accompanying table. These priorities are not listed in any 'ranked' order. All are considered to be equivalent priorities of BFCH.

Priority Need #1: Improve pregnancy outcomes, including a focus on pre-conceptual health.

A majority of overall pregnancy outcomes in the state continue to improve and are lower than the U.S. rates in many instances. However, the continuing racial and ethnic disparities in perinatal outcomes, and the rising VLBW and perinatal mortality rates are cause for concern and continuation of vigilant efforts in this area. BFCH recognizes that a woman's health status prior to becoming pregnant a key variable in her pregnancy outcome. Health promotion activities, freedom from domestic violence, food security and good nutrition, access to primary care and family planning are all necessary components to overall good health to ensure a healthy family.

Priority Need #2: Reduce adolescent risk factors and risk-taking behaviors, including among adolescents with special health care needs. Adolescent births have declined overall, but the chlamydia rate among females 15 –19 continues to rise. The experience of sexual violence has been highly associated with risk factors for STDs including number of partners and drug and alcohol use. The prevalence of mental health problems and access to services as risk factors is a major concern. The suicide rate among both 15 – 19 year olds has not improved and for 10 – 14 year olds it increased in 1998. Unintentional injuries remain an area of concern, with a rising rate of motor vehicle crash deaths among 15 – 19 year olds. Many positive trends can be seen in declines in cigarette smoking, riding with a drinking driver, and many sexual risk behaviors. However, the majority of high school students engage in some risk behaviors that pose serious threats to their health and safety. Also, risk behaviors tend to cluster together. Students who engage in one high-risk or health-compromising behavior are often likely to engage in other risk behaviors as well. This clustering also reveals the important interrelationships between one risk behavior (e.g. drinking) and other health consequences (e.g. dating violence).

Priority Need #3: A priority need is to improve oral health for children and youth, particularly those depending on publicly funded oral health coverage and those with special health care needs. Improvements in prevention and access to oral health care are critical needs for children and youth. Access to care for children covered through MassHealth is severely limited due to declining numbers of Medicaid-participating dentists and that safety net providers providing care to low income uninsured children is also in jeopardy. Children with special health care needs, particularly the large number covered by MassHealth, have even more restricted access to care. Prevention services such as fluoride mouthrinse programs for children in non-fluoridated communities and sealants are not widely implemented.

Priority Need #4: Enhance data systems and incorporate new technologies to support MCH service provision, data management, performance measurement and electronic service delivery, in a

managed care environment. BFCH has developed its capacity for electronic data collection and dissemination to a sophisticated level – for example, the implementation of Mass CHIP, a multi-database user-friendly web-based application that makes population health status data, data from other databases and demographic data publicly available. However, the efforts to implement such applications have also increased the awareness of the complexity, necessary skills, and costs of using these still-evolving technologies. A potential that remains largely unfilled is to create linkages among multiple databases to allow a more integrated analysis of maternal and child health status and services. A closely related issue is providing assistance in the availability of technology and knowledge capacity among local MCH providers and communities so that they can utilize developing applications.

Priority Need #5: Develop and implement an integrated system for early risk identification, follow-up, referral, services, and family involvement for children ages birth to 3. The Bureau has a number of programs and services for the birth to three population, including Newborn Hearing Screening, FIRSTLink, Primary Care, WIC, FIRSTLink, FIRSTSteps and Healthy Families Home Visiting programs, Early Intervention, Growth and Nutrition, and other specialized services for CSHCN in this age group. While significant effort to coordinate these services has been made, services are not integrated to the optimal extent on many levels, from program standards, referral flow, screening protocols, provider training and technical assistance, performance measures, and especially data linkage. In addition, there has been a significant and continuing expansion in state and federal funding for other services for the birth to three population in Massachusetts, including the Mass. Family Network (Department of Education), Early HeadStart, expanded child care services, and other local and private provider initiatives. Services for children birth to 3 is a special focus of the Bureau's Strategic Planning Process. There is also a statewide forum in which similar planning and efforts at coordination are occurring.

Priority Need # 6: Assess the impact of health care delivery, insurance, immigration, and welfare systems changes on access to and quality of care for women, children and youth and on MCH service programs. As responsibility for the structure of many programs affecting families and immigrants as devolved from the federal government to the states, Massachusetts has taken advantage of this flexibility to restructure its public insurance, welfare, and related benefit systems. To date, the results have been a significant increase in children and families insured through MassHealth (Medicaid), and a significant decrease in families receiving transitional assistance (welfare) and food stamps benefits. Immigrant women and families are still eligible to receive state-only benefits but are generally ineligible for federal benefits. The long-term impact of these massive system changes on health care utilization and health outcomes is still unknown.

Priority Need # 7: Develop and implement initiatives that address violence against women, children, and youth. Domestic violence and sexual assault have far-reaching effects on maternal and child health populations. The Governor declared domestic violence a public health emergency in 1992 based on the alarming number of cases of domestic homicide. Yet this is only the most severe outcome of a range of violence experienced by women and children. Nationally, intimate partner violence is the single major cause of injury to women and is associated with many other serious health problems including depression, anxiety, post traumatic stress disorder, chronic pain, gastrointestinal disorders, substance abuse, HIV infection, suicide, and pregnancy complications. While there is an extensive network of services, it is insufficient to meet the need, with almost 4000 women being turned away from shelter or safe home services in 1999. In addition, an increasing body of literature demonstrates serious consequences for children who live in homes where there is intimate partner violence. In addition to the effects of witnessing violence, numerous studies show direct connections between domestic violence and child abuse. The relationship between sexual assault and suicide for adolescents is also being better elucidated.

Priority Need # 8: Develop and implement public health programs and policies that promote positive mental health for the MCH population, and collaborate to improve access to appropriate mental health services. Across many diverse BFCH programs, mental health needs among the MCH population and a lack of mental health service capacity have been identified as critical issues. The state Department of Mental Health has limited resources and provides care to only those with severe chronic mental health diagnoses.

Priority Need # 9: Monitor and develop strategies to address childhood health conditions that are increasing in prevalence, including asthma and obesity. Childhood health conditions continue to change in prevalence, complexity and range of related issues. A systematic, proactive approach is needed to monitor and study these changing health issues, and develop appropriate public health strategies to address them. Asthma and obesity are two current examples of health conditions with rising prevalence, significant health implications and impact, and considerable complexity. This priority need allows the flexibility to shift that focus as warranted.

Priority Need #10: Improve accessibility and utilization of MCH services, with emphasis on 1) cultural competency; 2) service availability in rural areas; and 3) increasing public knowledge about MCH services. The BFCH makes every effort to assure that MCH services provided or funded

by the Bureau are available where underserved, high-risk populations reside. However, BFCH has identified through focus groups and surveys that many residents are neither specifically aware of the resources available nor how to access needed services. Program participants and parents repeatedly stress the need for greater flexibility in service availability, including days and time of day. Also, although cultural competency in service delivery is emphasized in all BFCH programs, the lack of services, especially mental health and substance abuse services, in appropriate languages has also been identified as a major concern in the needs assessment process. Other traditional barriers to service access continue to be a challenge for Massachusetts families, including transportation. This is especially problematic in the more rural areas of the state, with the relative isolation of many residents.

See Table 3.2.1, State Identified Priority Needs FY 2001 – 2005, on the next page. The State Priority Needs are also listed on **ERP Form 14**.

Table 3.2.1

State Identified Priority Needs FY 2001 – 2005

STATE PRIORITY NEED	POPULATIONS	LEVEL OF PYRAMID
1. Improve pregnancy outcomes, including a focus on pre-conceptual health.	(X) Pregnant women, mothers and infants () Children () CSHCN (X) Other: women of reproductive age	(X) Direct Services (X) Enabling (X) Population-based (X) Infrastructure
2. Reduce adolescent risk factors and risk-taking behaviors, including among adolescents with special health care needs.	() Pregnant women, mothers and infants (X) Children (X) CSHCN	(X) Direct Services (X) Enabling (X) Population-based (X) Infrastructure
3. Improve oral health for children and youth, particularly those depending on publicly funded oral health coverage and those with special health care needs.	() Pregnant women, mothers and infants (X) Children (X) CSHCN	(X) Direct Services (X) Enabling (X) Population-based (X) Infrastructure
4. Enhance data systems and incorporate new technologies to support MCH service provision, data management, performance measurement, and electronic service delivery, in a managed care environment.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN	() Direct Services () Enabling () Population-based (X) Infrastructure
5. Develop and implement an integrated system for early risk identification, follow-up, referral, services, and family involvement for children ages birth to 3.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN	() Direct Services (X) Enabling (X) Population-based (X) Infrastructure
6. Assess the impact of health care delivery, insurance, immigration, and welfare systems changes on access to and quality of care for women, children and youth and on MCH service programs.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN	() Direct Services () Enabling () Population-based (X) Infrastructure
7. Develop and implement initiatives that address violence against women, children, and youth.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN	() Direct Services (X) Enabling (X) Population-based (X) Infrastructure
8. Develop and implement public health programs and policies that promote positive mental health for the MCH population, and collaborate to improve access to appropriate mental health services.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN	() Direct Services (X) Enabling () Population-based (X) Infrastructure
9. Monitor and develop strategies to address childhood health conditions that are increasing in prevalence, including asthma and obesity.	() Pregnant women, mothers and infants (X) Children (X) CSHCN	() Direct Services () Enabling () Population-based (X) Infrastructure
10. Improve accessibility and utilization of MCH services, with emphasis on 1) cultural competency; 2) service availability in rural areas; and 3) increasing public knowledge about MCH services.	(X) Pregnant women, mothers and infants (X) Children (X) CSHCN	() Direct Services (X) Enabling (X) Population-based (X) Infrastructure

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

Please refer to **ERP Forms 2, 3, 4, and 5**.

The budget presented in ERP Forms 2, 3, 4, and 5 is quite similar to that for FY00. Some key points are highlighted. The total Partnership budget of \$98,346,478 is made up of \$13,529,124 of MCH Block Grant funds (including carry-forward funds) and \$84,817,354 in state funds. Massachusetts continues to commit funds far above our statutory maintenance of effort level from FY1989 of \$23.5M. The state funding represents a FY01 State Match (\$3 state for every \$4 federal) of \$10,146,843 and State Over Match of \$74,670,511. The state amount of the Partnership budget is tentative, however, as the Massachusetts state budget for FY01 (which began July 1, 2000) has not yet been passed and signed. Depending on the final outcome of budget deliberations, the Bureau could be receiving more money in some accounts than included here, but restrictions on the use of some funds could also be included. The total state funds represent all or portions of 14 state accounts (Family Health Services, Healthy Start, CMSP, Early Intervention (2 accounts), Newborn Hearing Screening, Teen Pregnancy Prevention, Tobacco Control Program funds for school health, 2 Interagency accounts with Medicaid, Dental Health, state administration, and two accounts from the tobacco settlement for expanded school-based health center and school health services). Details on the amount from each account are given in the Endnotes to Form 3. Two possible sizeable new accounts added by the Legislature (one for Early Intervention Respite and one for Family Planning Education and Outreach) have not been included in the budget yet, although the services that will result if they are funded have been included in the Annual Plan. The bulk of the increase in state partnership funds from FY00 (from \$77,884,161 to \$84,817,354) is due to the first year of full funding for the new Tobacco Settlement/School Health accounts.

The \$106,793,817 of other Federal funds shown on Form 3 comes from over 20 different grants, which cover all of the categories of the categories on Form 2 except federal Healthy Start. It is important to note that we include all of our WIC funds, state and federal, as they are budgeted in a seamless manner at the state level. Massachusetts funds WIC (both directly and with an infant formula retained revenue account) at over \$37M, which is included in the \$106.8M.

Not included in the budget forms is a substantial amount of state funding administered by the Bureau for MCH programs, but which cannot be listed as match by us because the funds are used for match for other federal programs (e.g. TANF) or which originate in other state agencies that wish to maintain their options to use the funds for match. As we have a substantial amount of over-match, this is not a budget issue for the Bureau, but it does undercount the level of state support for key MCH services. Some of these funds were included in the Partnership in FY00 or previous years. The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans. Some of the

accounts involved are fully MCH-related; these include Healthy Families (\$14,668,000) and FOR Families (\$3,030,000). Other accounts include both MCH-related and other activities that are difficult to identify precisely or which are needed for potential match for other purposes. These include five state-funded accounts that address sexual assault, batterer intervention, and violence prevention, one that supports food stamp outreach, and two that support community health center operations and initiative.

A revised budget will be submitted when the state budget is made final.

3.3.2 Other Requirements

Massachusetts maintains state MCH funding levels well above what is required for maintenance of effort from 1989. The Commonwealth has not had continuation funding for special projects or special consolidated projects in a number of years. Programs related to those federal categories continue in several cases but are competitively bid periodically in accordance with state purchase of service regulations.

3.4 Performance Measures

3.4.1 National “Core” Five Year Performance Measures

See Figure 4 on following pages. See **ERP Form 11** for annual indicators and 5 year targets.

3.4.2 State “Negotiated” Five Year Performance Measures

See **ERP Form 11** for annual indicators and 5-year targets and **ERP Form 16** for detail sheets on each measure. Rationales and priority relationships of State measures are shown in Table 3.4.2., which follows Figure 4.

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home.”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Massachusetts Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SP# 01) DELETED; NO LONGER IN USE.							
SP #02) The degree to which children with special health care needs and their families have appropriate health care management plans in place. (See checklist for components of measure)		X				X	
SP # 03) Percent of children and youth enrolled in Medicaid, CMSP, or Title XXI who receive any preventive (well-child) services annually.			X				X
SP #04) Percent of children and youth enrolled in Medicaid or CMSP who receive preventive dental services annually.			X				X
SP #05) The percent of women and adolescents who report not smoking during their current pregnancy			X				X
SP #06) The rate (per 1,000) of chlamydia cases among females aged 15 through 19			X				X
SP # 07) The degree to which the State assures that child care providers have access to qualified child care health consultants (See checklist for components of measure)				X	X		
SP #08) The degree to which the State assures nutrition screening and education, with referrals to assessment, counseling and services as indicated, for pregnant women, children and adolescents. (See checklist for revised components of measure)				X	X		
SP # 09) The degree to which there is a statewide system for early identification, referral, appropriate services, and care coordination for all at-risk children from birth to age 3. (See checklist for components of measure) - TEMPORARY		X				X	
SP #10 DELETED; NO LONGER IN USE							
SP #11) The percentage of pregnancies that are intended.			X				X
SP #12) The degree to which the State has developed and implemented comprehensive education, screening and referral protocols for violence against women and children. (See checklist for components of measure)				X		X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services

IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Table 3.4.2
Five Year State Performance Measures 2001 - 2005

SPM #	Rationale	Related to State Priority Need #	Level of Pyramid	Related to Outcome #
1	Original SPM #1 dropped; number not reassigned. See related new measure SPM#11.			
2	The need for comprehensive, family centered care plans for CSHCN continues to be an important component of care coordination and the concept of a “medical home”. The lack of a statewide system of care coordination for CSHCN is a major gap in Massachusetts.	2, 3, 5, 6, 8, 9, 10	Enabling Services	1-4, 6
3	Having health insurance is only the first step in assuring access to primary prevention services. The similar NPM # 13 seeks to ensure that children of low-income families actually are enrolled in Medicaid and receive a service. Consistent with the BFCH focus on prevention, the SPM adds the qualifier of a <i>preventive</i> (well child) service, and includes the entire state specific health insurance system (including CMSP).	2, 5, 6, 8, 9, 10	Population Based Services	1-6
4	This measure is an extension of SPM#3, with a focus on oral health. Children have significant unmet dental needs. One recent finding in Massachusetts showed that nearly 40% of children who were screened needed restorative dental care, with approximately 15% needing immediate referral. Low, income, minority children and CSHCN have particularly difficult access to dental care, with a lack of dentists who participate in Medicaid.	3, 4, 6, 10	Population Based Services	
5	Smoking is a major contributor to low birth weight, and other poor perinatal outcomes. Environmental tobacco smoke is also a health risk factor for infants and children. Massachusetts has seen improvement in this measure, and in lower rates of smoking in other populations, and will continue its aggressive efforts toward furthering this trend.	1, 2, 4, 6, 10	Population Based Services	1-5
6	Chlamydia is the most prevalent STD today, and is a marker for unprotected sexual activity. Untreated, it also can lead to significant health sequelae in women of reproductive age, including infertility, and poor perinatal outcomes. Unprotected sexual activity also increases the risk for HIV and unintended pregnancy. Early sexual activity in teens has also been associated with a history of sexual and physical abuse, substance use, and other major health risks.	1, 2, 4, 8, 10	Population Based Services	1-5
7	The numbers of children in child care settings has increased dramatically in recent years. Providers in these settings vary widely in their training and capacity to provide safe, healthy, nurturing, developmentally appropriate care. The availability of a system to support and increase the capacity of providers in these settings will benefit all children and families who use child care. It is also an opportune setting for primary child health and developmental screening, and to promote broad-based health and safety practices with parents, such as preventive health care.	3, 5, 6, 7, 8, 9, 10	Infrastructure Building	1-4, 6

SPM #	Rationale	Related to State Priority Need #	Level of Pyramid	Related to Outcome #
8	Nutritional status is the foundation of good health, and poor nutrition is a risk factor for numerous adverse health outcomes. Developing a system of nutrition support and services across all BFCH programs is a key step in assuring availability of a continuum from primary screening and education to referral to WIC and other food resources to specialized care when needed. This measure promotes a systems approach that includes broad public education, surveillance and proactive monitoring of nutrition related health conditions, in addition to screening, education, and referral at point of contact for all BFCH programs serving MCH populations.	1, 2, 3, 4, 5, 6, 9, 10	Infrastructure Building	1-6
9	This SPM has been expanded from a focus limited to at-risk newborns to the broader focus of at risk children birth to three. The state has a large and expanding number of programs and services for this population group, many with overlapping eligibility, goals, services, geographic service areas, etc. Building a system that ensures that potentially at risk infants are identified as early as possible, and that subsequent referrals and appropriate services are assured and coordinated, is critical to promoting optimal healthy outcomes for young children. There is also the need to reduce duplication for the effective and efficient utilization of limited resources, while also preventing at risk children and families from slipping through gaps.	3, 4, 5, 6, 7, 8, 9, 10	Enabling Services	1-6
10	Original SPM #1 dropped; number not reassigned	NA		
11	Unplanned pregnancy can be associated with adverse outcomes for mothers and infants. It has also been associated with other known health risks, including partner abuse, inadequate health insurance, medium or high risk for HIV, and smoking.	1, 2, 4, 6, 7, 8, 10	Population Based Services	1-6
12	Violence has been recognized as a serious public health issue that cuts across all the MCH priority populations. Intimate partner violence is the single major cause of injury to women and is associated with many other serious health problems including depression, anxiety, post traumatic stress disorder, chronic pain, gastrointestinal disorders, substance abuse, HIV infection, suicide, and pregnancy complications. Screening for the potential or actual occurrence of violence in the lives of women and children, and education and referral, are critical activities for all providers and programs with which this population interacts. This SPM also takes a systems approach, and was developed to bring progress in assuring that appropriate protocols are developed and implemented in all programs serving MCH populations, both within and external to BFCH.	1, 2, 4, 5, 6, 7, 8, 10	Infrastructure Building	1-6

Figure 3: Title V Block Grant Performance Measurement System

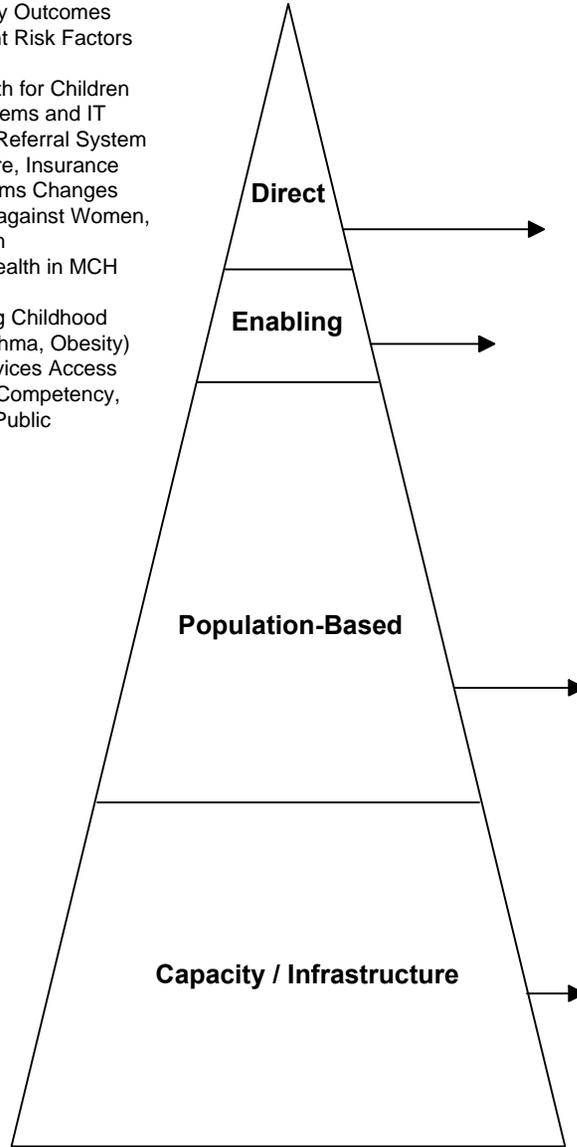
**Needs Assessment
Health Status Indicators**

Births
Deaths
Morbidity
Maternal risks
Oral health
Mental health
Special health care needs
Risk behaviors
Health care utilization
Health care financing/insurance
Social conditions
Environmental risks
Health care resources
Systems of care
Access to health data
Quality of health data
Listening to:
 families
 field staff
 key informants
Disparities
Models of care

Priorities

1. > Improve Pregnancy Outcomes
2. > Reduce Adolescent Risk Factors and Behaviors
3. > Improve Oral Health for Children
4. > Improve Data Systems and IT
5. > Early Risk ID and Referral System
6. > Monitor Health Care, Insurance and Welfare Systems Changes
7. > Address Violence against Women, Children and Youth
8. > Promote Mental Health in MCH Populations
9. > Address Increasing Childhood Health Issues (Asthma, Obesity)
10. > Improve MCH Services Access and Use (Cultural Competency, Rural Availability, Public Awareness)

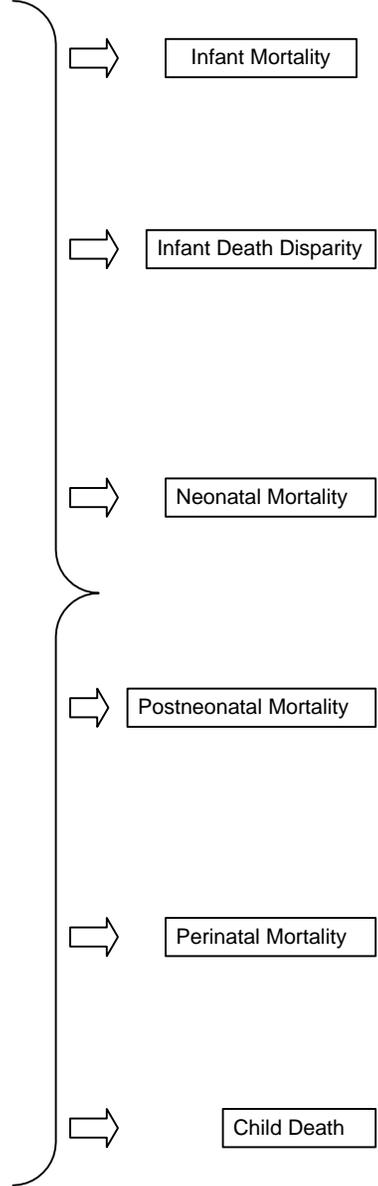
Levels of Service



Performance Measures

- CM 2-CSHCN Special Services
- CM 1-SSI
- CM 3-Medical Health Home
- MA 2-CSCHN Health Plans
- MA 9-Early ID System
- MA 3-Preventive Health Services
- MA 4-Preventive Dental Services
- MA 5-Smoking During Pregnancy
- MA 6-Teen Chlamydia
- MA 11-Intended Pregnancies
- CM 4-Newborn Screening
- CM 5-Children Immunized
- CM 6-Teen Births
- CM 7-Dental Sealants
- CM 8-Motor Vehicle Deaths
- CM 9-Breastfeeding
- CM 10-Newborn Hearing Screening
- MA 7-Child Care Health Consultants
- MA 8-Nutrition Systems
- MA 12-Violence Screening Protocols
- CM 11-CSHCN w/Insurance
- CM 12-Child Health Insurance
- CM 13-Medicaid Children
- CM 14-CSHCN Family Participation
- CM 15-Suicide
- CM 16-VLBW
- CM 17-VLBW at High Risk Facilities
- CM 18-First Trimester Prenatal Care

Outcomes



IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

NPM #1 –The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Population(s): () Pregnant Women, Mothers and Infants () Children (X) CSHCN

See also the narrative under this performance measure in the Annual Report.

TABLE NPM-1C

New or Continuing Programs/Activities

Programs/Activities	Pyramid
<p>Division for Special Health Needs</p> <ul style="list-style-type: none"> Because the Massachusetts Title V program virtually never pays for any direct medical, habilitative, or rehabilitative services for SSI beneficiaries under the age of 16, our score on this measure is 0%. [Note: This is a modification to previous scoring for this measure, in order to bring it into line with the format being used by other states with universal Medicaid coverage for these services.] All SSI beneficiaries in Massachusetts are automatically enrolled in Medicaid. The breadth of the Medicaid benefit package in the state leaves Title V with no residual responsibilities because "the extent medical assistance for such services is not provided by Medicaid" is zero. The Commonwealth's financial commitment to Medicaid permits Title V funding to be used for other services and initiatives. High among those are on-going efforts to make sure that all children who are eligible for SSI are enrolled and that their families are aware of the range of services to which they are entitled. 	<p>E, I</p>

TABLE NPM-1D

Programs/Activities to Be Reviewed or Revised

Programs/Activities	Pyramid
<p>Family and Community Support</p> <ul style="list-style-type: none"> Over the next year, with a new director, this program will shift from a freestanding model, to a model housed in medical home. The Bureau will issue an RFR (or design another approach to identify physicians who are interested and able to house a case manager), change the name to "Special Care Coordinator," and outstation in physicians' offices and hospital clinics. We will track involvement with specific families, but all CSHCN in the practice will be potential cases. We will also seek to provide much more training and information to other MD offices on how to meet the needs of CSHCN and their families. Through this change, and continued expansion of family-to-family, the Bureau aims to reach a much higher percentage of CSHCN. 	<p>E</p>

NPM #2 – The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Population(s): () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Massachusetts provides access to health insurance coverage for children with special health care needs and all programs have a focus to assure eligible children are aware of the various programs including CommonHealth. BFCH programs such as EI, Growth and Nutrition, and MassCare reimbursement for services not covered under third party coverage including Medicaid. The BFCH existing case management program (Family and Community Support) provides services to a subset of children with special needs. As we continue to work towards the assurance of a "medical home" for each child a major need has been identified for a comprehensive system for care coordination which is practice-based. It must be focused on families, rather than diseases and be accountable for its quality. This system should also identify gaps and problems and develop mechanisms to create solutions. The BFCH working with a diverse advisory committee will finalize the system design and implementation plan over the next year.

TABLE NPM-2C

New or Continuing Programs/Activities

Programs/Activities	Pyramid
Early Intervention	D, E
Regional Consultation Programs (RCP)	I
<ul style="list-style-type: none"> Statewide network of programs to increase capacity to address needs of children birth to 3 who have complex care requirements, multiple disabilities and extensive medical/health needs. 	
Family & Community Support	E
Growth & Nutrition	D
MassCARE	E
Mass. Genetics Program	I
MASSTART	I,E
Special Medical Fund	E
Universal Newborn Hearing Screening Program	
<ul style="list-style-type: none"> Reimburses hospitals for newborn hearing screenings for uninsured and underinsured newborns. Reimburses approved diagnostic centers for diagnostic hearing evaluations 	P, E
Enhanced School Health Services	I, E
Massachusetts Initiative for Youth with Disabilities (MIYD)	
Continuing SPRANS grant activities:	E, I
<ul style="list-style-type: none"> Making Healthy Connections group mentorship program <ul style="list-style-type: none"> Will hold two eight-session programs for youth ages 14 to 22 (one program in eastern Mass; one program in western Mass). Program focuses on promotion of self-management of health care. Other objectives include increasing awareness of opportunities for people with disabilities, enhancing skills needed for future independence such as self-advocacy, and gaining peer support and socialization opportunities. Emphasis in FY01 will be on program documentation and evaluation. Parent Transition Specialists <ul style="list-style-type: none"> Will continue to contract with Federation for Children with Special Health Care Needs to fund and further develop role of "Parent Transition Specialist," to serve as "experts" in adolescent-to-adult transition for youth with disabilities and special health care needs, and provide training and technical assistance to families and professionals. Emphasis will be on incorporating health transition into general transition training curriculum, which focuses on IEP development and implementation for transition-aged students 	

TABLE NPM-2D**Programs/Activities that Will Undergo Review or Revision**

Programs/Activities	Pyramid
Family and Community Support <ul style="list-style-type: none"> Over the next year, with a new director, this program will shift from a freestanding model, to a model housed in medical home. The Bureau will issue an RFR (or design another approach to identify physicians who are interested and able to house a case manager), change the name to “Special Care Coordinator,” and outstation in physicians’ offices and hospital clinics. We will track involvement with specific families, but all CSHCN in the practice will be potential cases. We will also seek to provide much more training and information to other MD offices on how to meet the needs of CSHCN and their families. Through this change, and continued expansion of family-to-family, the Bureau aims to reach a much higher percentage of CSHCN. 	E

NPM #3 – The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”
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Population(s): () Pregnant Women, Mothers and Infants () Children (**X**) CSHCN

See also the narrative for NPM2, and the discussion of Care Coordination for CSHCN in the Needs Assessment, section 3.1.2.1.
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TABLE NPM-3C**New or Continuing Programs/Activities**

Programs/Activities	Pyramid
Universal Newborn Hearing Screening Program <ul style="list-style-type: none"> The program is implementing a new grant funded through HRSA, the Massachusetts Hearing Linkage Project. A major goal of this grant is to ensure that each newborn that does not pass a newborn hearing screening has access to a medical home. Staff will perform outreach activities to ensure access to services to families with newborns that do not pass the hearing screenings, pediatricians, the Massachusetts Chapter of the American Academy of Pediatrics, health centers, nurse practitioners, and other primary care clinicians. 	E
Early Intervention	E
Family and Community Support	E
MassCARE	E
Growth and Nutrition Program	D
Combined Primary Care Program – Pediatric and Adolescent Components	D
School Health Services / Enhanced School Health <ul style="list-style-type: none"> The Department has issued 77 Enhanced School Health Service grants to develop school health service programs within the Commonwealth’s schools. A requirement is that all children be screened to determine whether they have a primary care provider. School nurses are expected to link children and families with primary care providers in all school districts, which are awarded these grants. The School Health Program has developed and distributed a sample emergency care form, which includes a question about the primary care provider. (The form is signed annually by the parent, should the child require emergency care.) This form should expedite the identification process. 	E
SBHC <ul style="list-style-type: none"> Expanding program sites: In 2001, the Bureau is funding an additional 24 new SBHC sites, making a total of 59 operational sites, with 22 more in the planning phase. Sites funded by the Department are required to determine whether students registered in the SBHC have a primary care provider. Children and their families without a primary care provider are 	D, E

Programs/Activities	Pyramid
provided with information and resources to assist them in selecting an appropriate primary care provider.	
MCH Home Visiting Programs – Healthy Families (HF) and FIRSTSteps (FS) <ul style="list-style-type: none"> • Home Visitors routinely link enrolled families with primary health care providers. They also assist in reducing barriers to regular care, such as transportation, child care, or other access issues. • The most recent Participant Data System (the electronic data reporting system) upgrade has greatly contributed to the efficiency and accuracy of data entry, which correlates to obtaining information about this performance measure. • The HF program has expanded to include 20 year olds. 	E
Massachusetts Initiative for Youth with Disabilities (MIYD) <ul style="list-style-type: none"> • Continuing SPRANS grant activities: Contract with Children’s Hospital in Boston to develop models of medical transition for adolescents with disabilities and special health care needs, to help ensure provision of coordinated, age-appropriate primary and specialty care for transition-aged youth and young adults 	E
FOR Families <ul style="list-style-type: none"> • Home visitors routinely link referred families to primary care providers, if they do not already have a medical home. 	E

TABLE NPM-3D

Programs/Activities that Will Undergo Review or Revision

Programs/Activities	Pyramid
Combined Primary Care Program <ul style="list-style-type: none"> • Work with the Bureau CSHCN program to evaluate ways in which CSHCNs can be identified in local programs. Activities may include focus group meetings with local program providers. 	D, E
Family and Community Support <ul style="list-style-type: none"> • Over the next year, with a new director, this program will shift from a freestanding model, to a model housed in medical home. The Bureau will issue an RFR (or design another approach to identify physicians who are interested and able to house a case manager), change the name to “Special Care Coordinator,” and outstation in physicians’ offices and hospital clinics. We will track involvement with specific families, but all CSHCN in the practice will be potential cases. We will also seek to provide much more training and information to other MD offices on how to meet the needs of CSHCN and their families. Through this change, and continued expansion of family-to-family, the Bureau aims to reach a much higher percentage of CSHCN. 	E

NPM #4 –Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (i.e., the sickle cell diseases) (combined).

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE NPM-4C

New or Continuing Programs/Activities

Programs/Activities	Pyramid
New England Regional Newborn Screening Program Continuing Program - <i>See detailed description in Needs Assessment Section 3.1.2.4: Population-based Services</i>	P, E
Mass. Genetics Program <ul style="list-style-type: none"> • Develop tools and conduct community and professional genetics needs assessments • Provide genetics educational material and in-service trainings. • Develop Mass. Public Health Genetics Strategic Plan and recommendations for genetics public health policy development 	I

NPM #5 –Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B

Population(s): () Pregnant Women, Mothers and Infants (X) Children () CSHCN

TABLE NPM-5C

New or Continuing Programs/Activities

Programs/Activities	Pyramid
Children's Medical Security Plan	E
Combined Primary Care Program – Pediatric Component <ul style="list-style-type: none"> • Specific performance measure for contracting programs related to immunization 	D, E
WIC <ul style="list-style-type: none"> • <input type="checkbox"/> Immunization assessment, education, referral, monitoring and follow-up are provided at all certification and re-certification appointments of infants and children. This is a contract performance measure. • <input type="checkbox"/> Two immunization in-service education programs were conducted for local program staff • <input type="checkbox"/> Targeted technical assistance is provided to local programs when the % of 2 year olds who have completed the primary series is below the state average 	E
MCH Home Visiting Programs – Healthy Families (HF) and FIRSTSteps (FS) <ul style="list-style-type: none"> • Home visitors monitor the immunization status of all children in enrolled families, provide education to parents on the immunization, and assist families as needed to ensure that children are fully immunized. • The most recent Participant Data System upgrade has corrected the technical problems that resulted in the loss of historical immunization data, when new data was entered. All data is now being entered and stored accurately. 	E
For Families <ul style="list-style-type: none"> • Home visitors screen referred families for access and connection to a primary care provider, and for health care needs including immunization, with education and referrals provided as needed. 	E

Programs/Activities	Pyramid
<p>Growing Up Healthy” (child health diary)</p> <ul style="list-style-type: none"> • “Growing Up Healthy/Creciendo Sano/Crescer Saudável”, will be distributed in English, Spanish and Portuguese universally through birthing hospitals to ensure age-appropriate access to and utilization of primary care, as well as to ensure age-appropriate, enhanced health supervision and content of care based on national Bright Futures Guidelines. Timely immunizations are addressed in the 15 well-child visit documentation pages, the inclusion of a special pocket for the Massachusetts Lifetime Immunization Record and a reminder card inserted into each book, and text describing the recommended schedule and listing vaccine-preventable diseases. 	<p>P, I</p>
<p>Max Care (state Healthy Child Care America project)</p> <ul style="list-style-type: none"> • Workshops will be conducted on immunization, infection control, health and safety in child care, licensing updates to child care providers and licensers will promote compliance with immunization recommendations and regulations. In addition, telephone technical assistance and mailed print materials will be delivered to child care providers with specific questions and concerns about immunizations, vaccines, and vaccine-preventable diseases. Data will be collected in an annual immunization survey and audit. 	<p>I</p>

TABLE NPM-5D

Programs/Activities that Will Undergo Review or Revision

Programs/Activities	Pyramid
<p>Children's Medical Security Plan</p> <ul style="list-style-type: none"> • CMSP will begin the implementation of a modified managed care program. In the last 6 months of FY01, enrollees will be encourage to sign-up with a primary care provider who is part of the CMSP network. The responsibility of this provider will be to encourage the use of established EPSDT preventive services for its panel. The implementation of this model will encourage the use of more immunization services and better reporting. • Establishment of refined quality assurance program to monitor compliance. As vaccines are available at no charge, current claims data only reflects administration of vaccine with the majority of vendors not billing \$0.00 for the CPT specific to the individual vaccines. 	<p>E E</p>
<p>MCH Immunization Program</p> <ul style="list-style-type: none"> • <input type="checkbox"/> After several months of evaluation, the Massachusetts Immunization Information System (electronic immunization tracking system) was recently shut down. The Bureau will work with programs to continue to address and improve immunization rates for the at risk population served. We are anticipating implementation of a web-based tracking system in approximately five years and will work with the MIP, and with local programs toward that end. 	<p>I</p>

NPM #6 – The birth rate (per 1,000) for teenagers aged 15 through 17 years.

TABLE NPM-6C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Office of Adolescent Health and Youth Development</p> <ul style="list-style-type: none"> • □ This new Office is committed to enhancing the health status of youth and adolescents utilizing a holistic youth development perspective by incorporating strength based strategies for risk reduction.. All programs and coordinated initiatives promote strategies to increase resiliency and protective factors utilizing an asset-based approach. Community based services are targeted to youth at-risk for HIV/AIDS/STD, pregnancy, substance and tobacco abuse, violence, inadequate physical activity, and poor nutrition. • □ The office provides technical assistance at all levels to ensure a continuum of comprehensive and developmentally-appropriate care across primary, secondary and tertiary prevention and intervention across school and community. Additionally, the office serves as a clearinghouse and resource regarding successful national, state and community program models, particularly in communities of color with significant health disparities. 	<p>I</p>
<p>Family Planning</p> <ul style="list-style-type: none"> • Site visits, program monitoring and technical assistance to family planning agencies to ensure compliance with program standards including specific standards on services to adolescents. • Ongoing clinical service provision to adolescents through statewide system of family planning agencies Ongoing collaboration with Keep Teens Healthy, a Medicaid sponsored program providing family planning outreach to high risk teens. • Ongoing collaboration with the Challenge Fund, a statewide teen pregnancy prevention program. • Initiation of training needs assessment with family planning service providers, including assessing needs for training on issues related to service provision to adolescents. • Ongoing Specialized and Enhanced Outreach services targeted to adolescents, for example a reproductive health group with Cambodian youth in Attleboro. Pending additional state funding, these initiatives will be expanded in fiscal year 2001. • Collaboration with Women’s Health Network to provide family planning information and referral through an 800 number. Initiated in 2000 and ongoing in 2001. • In collaboration with the Massachusetts Medical Society, promotion of emergency contraception through an education campaign with clinicians. • Explore and develop other strategies for the promotion of family planning such as newsletters, radio, and PSAs, including strategies specific to adolescents. Initiation of activities pending additional state funding. 	<p>D, E, I</p>

Programs/Activities	Pyramid
<p>Abstinence Education Campaign</p> <ul style="list-style-type: none"> • Develop and broadcast 2 new Television ads targeting young males 20-24 years old and 5 Radio messages targeting youth 15 – 17 years old, young males 20 –24 years old and parents. The messages will be designed to meet the following Federal legislative mandates: <ul style="list-style-type: none"> ➤ Support parents to instill positive values and set clear limits and behavioral expectations for their children ➤ Educate youth about the impact of alcohol and other substances have in relationship to sexual assault and the ability to remain abstinent ➤ Increase community awareness regarding the sexual exploitation of young females by older males • Re-broadcast FY 2000 Television and Radio messages for youth 15 – 17 years old and parents • Develop and broadcast 4 additional Radio messages for youth 15 – 17 years and parents to meet the Federal legislative mandates. • Continue to participate and distribute educational materials in local events and forums including health fairs, conferences, community events, and others. • Continue to distribute Television and Radio messages through the Massachusetts prevention systems, faith based organizations, youth-serving organizations, libraries, school based health centers, neighborhood and community centers, parent groups, and others • Continue to distribute parent Education film with Discussion Guide through the Massachusetts prevention centers, parent groups, faith based organizations, neighborhood and community centers, and others • Continue to distribute Collaterals items through the Massachusetts prevention systems, faith based organizations, youth-serving organizations, libraries, school based health centers, neighborhood and community centers, parent groups, and others • Design and develop new collateral items for youth 15 – 17 years old and parents • Design and develop new education materials for young males 20 – 24 years old and parents. • Continue to expand and integrate of abstinence with other youth health/wellness areas 	<p>I, P</p>
<p>Teen Pregnancy Prevention Challenge Fund</p> <ul style="list-style-type: none"> • Implementation of approximately 10,000 on-going primary prevention activities in 17 selected communities with high teen birth rates, serving a minimum of 130,000 youth participants on health topics including alcohol/other drugs, dating violence, HIV/AIDS, STDs, human sexuality, reproductive health, life opportunities, and overall community health • Implementation of a minimum of 8,000 one-time primary prevention activities in 17 selected communities with high teen birth rates, serving a minimum of 170,000 participants, including youth, parents and other community members • Continued funding of five young men’s programs in non-Teen Challenge Fund designated communities (Quincy, Salem, Malden, Somerville and Cambridge) • Continuation of school abstinence-based programs in Orange, Lawrence, Pittsfield and North Adams • Coordination of efforts with Prevention Centers to provide on-going technical assistance and trainings to Teen Challenge Fund coalitions through site-visits, regional and statewide meetings • Implementation of a statewide youth/providers conference to increase statewide capacity re: youth development and teen pregnancy prevention strategies • Continuing implementation of process evaluation in three selected Teen Challenge Fund communities • Begin implementation of outcome evaluation in three selected Teen Challenge Fund communities 	
<p>MCH Home Visiting Programs</p> <ul style="list-style-type: none"> • Home visitors provide education and referral to family planning programs for teen mothers, to prevent future unintended pregnancies 	<p>E</p>
<p>School-Based Health Centers</p> <ul style="list-style-type: none"> • Expanding program sites: In 2001, the Bureau is funding an additional 10 new SBHC sites serving this age group. In addition to providing anticipatory guidance, clinical staff assess and counsel students at risk for pregnancy. • Each funded high school site has a performance measure that 1) requires that at least 85% of 	<p>E</p>

Programs/Activities	Pyramid
<p>registered users be assessed for sexuality risk factors and 2) requires that 100% of the students determined to be a risk for pregnancy be counseled on means to avoid pregnancy.</p> <ul style="list-style-type: none"> The Bureau is also funding special projects in 3 high schools that will include components that further support pregnancy prevention activities. 	
School Health Services – Enhanced School Health	E
Combined Primary Care Program – Adolescent Component	D, I
<ul style="list-style-type: none"> The adolescent primary care program will work with other adolescent-serving programs to identify activities that will enhance adolescent services at local CPC – Adolescent programs. 	

TABLE NPM-6D

Programs/Activities that Will Undergo Review or Revision

Programs/Activities	Pyramid
Combined Primary Care Program – Adolescent Component	D, E
<ul style="list-style-type: none"> Review of program model and identify changes that might be necessary to more effectively serve adolescents 	
MCH Home Visiting – Healthy Families	E
<ul style="list-style-type: none"> Review of training component Review of data to evaluate if the program has been successful in delaying second teen pregnancies and to identify changes that might be necessary 	

NPM #7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Population(s): () Pregnant Women, Mothers and Infants (**X**) Children () CSHCN

TABLE NPM-7C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
Office of Oral Health	I
<ul style="list-style-type: none"> The Office of Oral Health is continuing its oral health initiatives to increase the percentage of third graders who have received protective sealants on at least one permanent molar. In FY00, the Office of Oral Health, in collaboration with the Massachusetts Coalition for Oral Health (MCOH), began developing multiple dental sealant models for the delivery of preventive services to low-income and minority children. Beginning in October 2000, (FY01) the Office plans to demonstrate these models in an eight-site dental sealant program. The MCOH has applied to the Delta Dental Foundation of Massachusetts for the funds (\$75,000) to implement the proposed project. Notice of funding is expected in August 2000. In addition, the Office of Oral Health plans to partner with the MDPH Primary Care and School Health units to assist in the expansion of the sealant pilot program to serve more children. Both units have received funds to expand services to include oral health. The OOH will continue to collect data through the BRFSS and through its collaboration with the Division of Medical Assistance and private dental insurers. 	
Combined Primary Care Program	D, E
<ul style="list-style-type: none"> Programs' contract and site visit language includes screening and referral for dental services. 	
MaxCare	I, E
Growing Up Healthy	P, I
Children's Medical Security Plan (CMSP)	E
<ul style="list-style-type: none"> Oral Health Services were implemented in May, 2000. Full implementation of the program and further dissemination of benefit information will continue in FY01. We are working with an 	

Programs/Activities	Pyramid
established network of dental providers and will work with them through our vendor in establishing and monitoring a preventive model of care for our enrollees. Since our caseload has not had access to this benefit in the past -- we will use the first year for establishment of baselines and quality assurance monitoring clinical outcomes for our enrollees.	
School Health Services / Enhanced School Health <ul style="list-style-type: none"> • Nursing leaders of the Enhanced programs are required to complete a plan (by the end of Year 2 in the contract) for assessing and improving oral health programs. The plan includes the following: <ul style="list-style-type: none"> ➤ Provision of dental sealant programs either directly or through referrals; ➤ Implementation of school-based fluoride rinse programs in communities with non-fluoridated water; ➤ Review of vending machines, school activities (events and fund-raisers), and food services with the goal of reducing sugar and starch intake; and ➤ Implementation of guidelines to ensure mouth-guard use in relevant contact sports. • The School Health Program, collaborating with the SBHCs, will recruit a dental hygienist to provide consultation to schools as they develop their oral health programs 	D, E, I P

NPM #8 – The rate of deaths to children under age 14 caused by motor vehicle crashes per 100,000 children.

Population(s): () Pregnant Women, Mothers and Infants (**X**) Children () CSHCN

TABLE NPM-8C
Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
Unintentional Injury Prevention – Child Passenger Safety <ul style="list-style-type: none"> • Continue staffing the toll-free telephone line for consumers and providers • Increase promotion of the toll-free telephone line via a new brochure • Ongoing participation in child safety seat checkpoints through the statewide planning process • Participate in a radio program on Child Passenger Safety on a Portuguese radio program • Ongoing facilitation of monthly meetings of the Partnership for Child Passenger Safety • Continued implementation of the Grand Rounds for Child and Youth Passenger Safety • Dissemination of materials to consumers • Up-date the car seat loan program list • Participate in the State Fire and Life Safety Conference – specifically with a session on child passenger safety • Participation and promotion of Child Passenger Safety Week activities • Promotion of Back to School Safety Campaign • Promotion of the primary enforcement belt law, pending passage of legislation 	P, I
School Health Services <ul style="list-style-type: none"> • The School Health program will continue to work with the injury prevention program to promote the use of seat belts. 	P, E
School-Based Health Center <ul style="list-style-type: none"> • Expanding program sites: In 2001, the Bureau is funding an additional 13 new SBHC sites serving this age group. In addition to providing anticipatory guidance about safety practices, clinical staff assess and counsel students at risk for injury. • Each funded elementary school site has a performance measure that requires 1) at least 85% of registered users be assessed for safety risk factors and 2) 100% of the students determined to be at risk for injury be counseled on seat belt use. 	D, E

Programs/Activities	Pyramid
MCH Home Visiting Programs <ul style="list-style-type: none"> Home visitors provide passenger safety information and education to parents Home visitors assist parents in obtaining a car seat and provide information on its correct and safe use. 	E
Combined Primary Care Program <ul style="list-style-type: none"> Education on passenger safety is provided to parents 	E
WIC <ul style="list-style-type: none"> Education on passenger safety is provided to parents 	E
FOR Families <ul style="list-style-type: none"> Home visitors provide passenger safety information to parents 	E
“Growing Up Healthy” (child health diary) <ul style="list-style-type: none"> “Growing Up Healthy/Creciendo Sano/Crescer Saudável” will be distributed in English, Spanish and Portuguese universally through birthing hospitals to ensure age-appropriate access to and utilization of primary care, as well as to ensure age-appropriate, enhanced health supervision and content of care based on national Bright Futures Guidelines. Child passenger safety is addressed in sections for parents to reference before leaving the hospital and up through age 6. Additional resources assist parents in obtaining information about car seat recalls, loan programs, and other passenger safety information. 	P, I
MaxCare <ul style="list-style-type: none"> Education on passenger safety 	I
Office of Adolescent and Youth Development <ul style="list-style-type: none"> Education and initiatives targeted to teens on driving and passenger safety, substance abuse and drinking and driving 	I

NPM #9 – Percentage of mothers who breastfeed their infants at hospital discharge.

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE NPM-9C

Programs/Activities that are new or Will Continue

Programs/Activities	Pyramid
WIC <ul style="list-style-type: none"> Pregnancy Nutrition Surveillance System will continue to collect WIC data Breastfeeding initiation contract performance measure. All prenatal women will be counseled on the benefits of breastfeeding. Prenatal infant feeding groups, which discuss the benefits of breastfeeding, are offered by many local programs. Breastfeeding incentives are provided for pregnant women. Local programs will celebrate World Breastfeeding Week with a variety of promotional activities including health fairs, baby showers, fashion shows, and trainings for health care providers. Media coverage will be obtained for many of these events. USDA “Loving Support Makes Breastfeeding Work” promotion campaign materials are used by local programs for participant education. The Breastfeeding Promotion Task Force meets regularly to share information and ideas on increasing initiation rates The “Mother to Mother” Breastfeeding Peer Counselor Program functions to promote breastfeeding to pregnant women. The Breastfeeding Basics in-service training will be offered twice for paraprofessional and professional staff. An Advanced Breastfeeding Training is offered to staff as well. Breastfeeding promotion information is developed and distributed to participants; training materials 	E

Programs/Activities	Pyramid
<p>were developed and distributed to nutrition staff.</p> <ul style="list-style-type: none"> Local programs employ 11 International Board Certified Lactation Consultants and 16 CLCs. 	
<p>MCH Home Visiting Program</p> <ul style="list-style-type: none"> Home visitors receive training on the principles and practice of breastfeeding, and supporting the breastfeeding mother Home visitors provide pregnant women education on the benefits of breastfeeding, and offer practical information and support to breastfeeding mothers Some programs have lactation consultants on staff or available to counsel mothers as needed Breastfeeding information is collected and monitored through the participant data system. 	E
<p>Combined Primary Care Program: Perinatal Component</p> <ul style="list-style-type: none"> Providers actively promote breastfeeding with pregnant women The percentage of women who breastfeed is a performance measure of the program. Since data to date has been inconsistent, the CPCP intends to evaluate how to improve data collection, and then assess local program needs related to improving breastfeeding rates. 	E
<p>Healthy Start</p> <ul style="list-style-type: none"> Relevant information and prenatal education, including breastfeeding and WIC, are mailed to enrolled pregnant women in each trimester Referrals to WIC are made by Health Access specialists in phone contacts with pregnant women 	E
<p>“Growing Up Healthy” (child health diary)</p> <ul style="list-style-type: none"> “Growing Up Healthy/Creciendo Sano/Crescer Saudável”, will be distributed in English, Spanish and Portuguese through birthing hospitals to ensure age-appropriate access to and utilization of primary care, as well as enhanced health supervision and content of care based on national Bright Futures Guidelines. Six pages encourage, instruct, and support parents to choose breastfeeding. Resource section identifies lactation resources. 	P, I

TABLE NPM-9D

Programs/Activities that Will Undergo Review or Revision

Programs/Activities	Pyramid
<p>WIC</p> <ul style="list-style-type: none"> Conducting review and initiating new emphasis on continuing breastfeeding beyond the initial months. 	E

NPM #10 – Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE NPM-10C
Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Universal Newborn Hearing Screening Program</p> <ul style="list-style-type: none"> • The Universal Newborn Hearing Screening Program is responsible for implementation of Chapter 243 of the Acts of 1998. Some of the key activities are the following: <ul style="list-style-type: none"> ➤ Ensures that each newborn in Massachusetts receives a hearing screening at birth. ➤ Staffs and holds regular meetings of the Universal Newborn Hearing Screening Advisory Committee. ➤ Provides technical assistance to hospital screening programs. ➤ Reviews hospital protocols for newborn hearing screening. ➤ Provides payments for hearing screenings and diagnostic evaluations for uninsured and underinsured newborns. ➤ Performs outreach to families and professionals ➤ Provides a toll-free number 1-800-882-1435 for technical assistance. • The program will be amending the electronic birth certificate system to include the results of each newborn hearing screening. This information will be used to begin tracking newborns that do not pass a hearing screening for the purpose of ensuring early access to diagnostic testing prior to three months of age and access to Early Intervention for babies diagnosed with hearing loss prior to six months of age. • The Universal Newborn Hearing Screening Program is also applying for a grant through the Centers for Disease Control to enhance the ability to systematically track newborns from the screening at birth, through diagnoses and into Early Intervention. This grant will also provide the program with the capacity to connect with FIRSTLink and with the congenital anomalies surveillance systems in the Bureau. • Since passage of the law, Massachusetts has made great progress in the numbers of newborns who have received hearing screenings prior to discharge from a birth center or hospital. It is expected that during fiscal year 2001, approximately 95% of all newborns will receive newborn hearing screenings. This percentage has been determined using hospital newborn hearing screening protocols that have been submitted to the Department of Public Health during fiscal year 2000. 	<p>P, I</p>

NPM #11 – Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Population(s): () Pregnant Women, Mothers and Infants () Children (X) CSHCN

TABLE NPM-11C
Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
SSI and Public Benefits Outreach, Training, Technical Assistance and Policy Activities <ul style="list-style-type: none"> Continuing Programs of Trainings and Technical Assistance in the area of SSI and public benefit programs for children with special health care needs Chair the SSI Networking Group 	E
Early Intervention Program <ul style="list-style-type: none"> Before an EI program can be paid with DPH state funds, referral must be made to MassHealth. 	E
MassCARE	E
Growth and Nutrition Program <ul style="list-style-type: none"> Families of all enrolled children are given information on insurance and enrollment. All enrolled children have a primary care provider (a medical home) in place. Program intake form contains information on insurance and medical home to facilitate monitoring of this measure 	D, E
Family & Community Support <ul style="list-style-type: none"> <input type="checkbox"/> Provides case management & assistance to families to enroll in public benefits programs 	E
School Health Services / Enhanced School Health <ul style="list-style-type: none"> The 77 school districts with Enhanced grants are required to identify all children who lack a primary care provider and/or health insurance. They must then be linked with either the provider or a public health insurance program. Data will be collected on the numbers of children identified and referred for either a primary care provider or health insurance. (See previous discussion on the use of the emergency card for this purpose.) 	E
School-Based Health Centers <ul style="list-style-type: none"> Expanding program sites: In 2001, the Bureau is funding an additional 24 new SBHC sites. Each site funded by the Department is required to determine whether students registered in the SBHC are insured. Children and their families without insurance are assisted in enrolling in insurance plan. Each funded SBHC site has a performance measure that requires eligible children/families be assisted in applying for insurance. 	E, D
FOR Families <ul style="list-style-type: none"> Referrals on an as needed basis for families requiring CSHCN services to case management program and for SSI application assistance. 	E
Combined Primary Care Program <ul style="list-style-type: none"> Work with the CSHCN program to evaluate ways to identify CSHCN in local primary care programs. Activities may include focus group meetings with local program providers. 	I, E
WIC <ul style="list-style-type: none"> Families of all enrolled children are given information on insurance and how to enroll. 	E

Programs/Activities	Pyramid
<p>benefits, policy, and procedures to assist potential enrollees with application process</p> <ul style="list-style-type: none"> ➤ Visit medical offices and health clinics to promote CMSP and HS to health care providers, answer questions, and provide CMSP and HS materials. ➤ Promote and assist with access to other related maternal and child health programs, especially BFCH and MassHealth programs. 	
<p>Massachusetts Projects for Health Care Access</p> <ul style="list-style-type: none"> • These projects provide community-based outreach, marketing, and enrollment assistance to uninsured and underinsured children, families and individuals enrolling in MassHealth and the Children's Medical Security Plan, with special emphasis on families and individuals who have not been easily identified or served through traditional approaches and strategies. The mini-grants have been used to leverage many other sources of funds to help address the health care access needs of communities, including Robert Wood Johnson "Covering Kids" grants, Federal Office of Rural Health "Moving Beyond Enrollment" funds, Massachusetts Medical Society "Compass" awards, hospital community benefits, and other agency resources. • Examples of activities and approaches include 1) collaborative efforts between County Governments and Native American organizations, 2) community health workers to provide outreach to low-income neighborhoods with a large Latino population, uninsured users of the local health center, three area schools; and 3) a city-wide campaign that provides Parent Information Centers, PSAs, bilingual literature production and distribution, and a public health van. 	E
<p>Combined Primary Care Programs – Pediatric and Adolescent Components</p> <ul style="list-style-type: none"> • Programs provide financial screening and support services to ensure clients are enrolled in appropriate health insurance. • The program will work with the Health Access Unit to identify ways that the programs might identify and track mutual program participants/clients. It is expected that this will increase the ability to assess how well programs are identifying and reporting children without health insurance, and ensuring their enrollment in an appropriate plan. 	D, E
<p>School Health Services / Enhanced School Health</p> <ul style="list-style-type: none"> • The 77 school districts with Enhanced grants are required to identify all children who lack a primary care provider and/or health insurance. They must then be linked with either the provider or a public health insurance program. • The School Health Program is working with both the Children's Medical Security Plan staff and the MassHealth staff to encourage school health service programs to apply for the currently available "mini-grants" for coordination and outreach. • The School Health Program continues to encourage all public school districts to participate in Municipal Medicaid, Part B, where federal funds are reimbursed to the community for coordination and outreach to MassHealth children (by school nurses and certain other school personnel). To date, approximately 240 communities participate in this program. They are encouraged to track the funds and advocate that some are returned to the school health programs in their local districts. 	E
<p>School-Based Health Centers</p>	D, E
<p>MCH Home Visiting Program</p> <ul style="list-style-type: none"> • Home visitors refer and assist families without health insurance to enroll in MassHealth or CMSP 	E
<p>FOR Families</p> <ul style="list-style-type: none"> • Include printed information, materials and applications in all home visiting contacts with families. • Include screening questions in all telephone contacts with families. • Make referrals to programs and services (e.g., Health Access Unit) to complete applications for insurance programs. 	E
<p>Early Intervention</p> <ul style="list-style-type: none"> • All children are screened for health insurance at enrollment, and all uninsured are encouraged and assisted to apply for MassHealth 	E
<p>Teen Pregnancy Prevention Challenge Fund</p> <ul style="list-style-type: none"> • Implementation of a minimum of 80 community-wide activities specifically focused on health insurance, serving a minimum of 700 youth • Continuing MIS technical assistance for contractors in order to better document activities that increase young people's access to health insurance 	I

Programs/Activities	Pyramid
SSI and Public Benefits Outreach, Training, Technical Assistance and Policy Activities	E, I
“Growing Up Healthy” (child health diary) <ul style="list-style-type: none"> • “Growing Up Healthy/Creciendo Sano/Crescer Saudável”, the child health diary, will be distributed in English, Spanish and Portuguese universally through birthing hospitals to ensure age-appropriate access to and utilization of primary care, as well as to ensure age-appropriate, enhanced health supervision and content of care based on national Bright Futures Guidelines. Health insurance access is addressed in 3 pages for parents to read before leaving the hospital and a comprehensive list of resources is provided. 	P, I
Max Care <ul style="list-style-type: none"> • All workshops include presentation of and materials relevant to enrollment in state insurance programs. Child care programs and Child Care Resource and Referral agencies will be encouraged to submit proposals for Health Access Outreach mini-grants. 	I

NPM #13 – Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Population(s): () Pregnant Women, Mothers and Infants (**X**) Children () CSHCN

Enrollment in health insurance is only the first step in assuring access. MCH programs all include a major focus on assisting families to utilize and obtain services available. This is reflected in educational material, performance measures, and a special emphasis on identifying and addressing barriers to obtaining services (see also activities in table NPM 12C).

TABLE NPM-13C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
Combined Primary Care Program – Pediatric and Adolescent Components	D
School-Based Health Centers <ul style="list-style-type: none"> • Expanding program sites: In 2001, the Bureau is funding an additional 24 new SBHC sites. • Each School-Based Health Center obtains insurance information and is expected to bill third parties (including Medicaid) for reimbursable services 	D, E
School Health Services / Enhanced School Health See NPM #12 : Municipal Medicaid	E
WIC <ul style="list-style-type: none"> • Referrals to health care providers are made for enrolled children. Provision of referrals is a core standard for site evaluation. • Require evidence of immunization and preventive medical care. Immunization rates are a contract performance measure. 	E
MCH Home Visiting Programs <ul style="list-style-type: none"> • Assist parents with barriers to access to care, such as transportation and child care; some programs transport enrolled parents and children to medical appointments, & make referrals made to primary and specialty health care providers 	E, D

Programs/Activities	Pyramid
FOR Families	E
<ul style="list-style-type: none"> Conduct follow up, outreach & referral to families with children to primary pediatric care services. 	
Early Intervention	D, E
<ul style="list-style-type: none"> Families of enrolled children are assisted with barriers to access to care Referrals routinely made to primary and specialty health care providers as needed 	
SSI and Public Benefits Outreach, Training, Technical Assistance and Policy Activities	E, I
Family and Community Support	E
Children’s Medical Security Plan (CMSP)	E
<ul style="list-style-type: none"> Before enrollment into CMSP all children are first screened for MassHealth eligibility (Medicaid and SCHIP programs); only children denied MassHealth are enrolled in CMSP. Many CMSP children are “retroactively enrolled” in MassHealth; for these children, CMSP denies payment for rendered services and directs providers to bill MassHealth. If they are not a MassHealth provider, CMSP will pay for the services. At the end of every fiscal year, every claim not paid due to MassHealth retroactive enrollment is reviewed and matched against MassHealth provider files. Continued collaboration with MassHealth ensure that the appropriate programs are responsible for payment for services rendered to enrollees in both MassHealth and CMSP 	
Massachusetts Bright Futures	P
<ul style="list-style-type: none"> Education campaign on the importance of receiving preventive health care. Collaboration with DMA to develop tools to encourage parents to utilize preventive services 	

TABLE NPM-13D
Programs/Activities that Will Undergo Review or Revision

Programs/Activities	Pyramid
Combined Primary Care Program – Pediatric and Adolescent Components	I
<ul style="list-style-type: none"> Data on the CPCP providers’ rates for providing EPSDT services is currently unavailable from DMA. The CPCP will be revising contractor reporting to obtain additional information, and will work with DMA to explore possible ways that DPH may be able to obtain this information. 	

NPM #14 – The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Population(s): () Pregnant Women, Mothers and Infants () Children (X) CSHCN

The Division for Special Health Care Needs (DSHN) works intimately with families in order to develop policies and programs that ensure that services are integrated to meet the needs of families in diverse communities. It is essential that all programs and initiatives support family choice and decision making, respect and support unique and diverse family values, priorities and changing needs and build productive family-provider partnerships. To accomplish this, efforts are made to include family members in every initiative from its earliest stage so that families can be part of the planning, implementation and evaluation. Having several parents who serve in program management positions and one parent who is part of the DSHN senior management team ensures that parents are involved in all aspects of the Division’s work. This promotes the integration of numerous initiatives and facilitates the establishment of multiple and flexible approaches to accomplishing the goals of assurance, coordination, inclusion of all families and targeted outreach. Overviews of staffing levels and activities and support are also provided in Section 1.5.1.3 and in Supplemental Documents Section 5.3.10 (BFCH Program Descriptions). The following table summarizes planned activities, new opportunities, and problems to be addressed during FY01 to enhance parent participation in relationship to each component of this measure.

TABLE NPM-14C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Division for Special Needs</p> <ul style="list-style-type: none"> • Family member participation on advisory committees, task forces, block grant, and other settings • Provision of financial support (financial grants, travel, parking, child care, etc.) for parent activities and parent groups. • Family member involvement in in-service training of DSHN staff and providers. • Interactive “Essential Allies” training on family participation in advisory activities. • Information and referral: toll free in-state phone line (1-800-905-TIES); central directory of EI programs throughout the state; computerized data base; information on public benefits and other services, directory of resources for families of children with special needs and packets of current information on diagnoses, resources, services, support groups, etc. • Parent to parent linkage: connections with other groups providing parent to parent support services and provision of training for support parents. • Early Intervention Parent Leadership Project: networking among parents throughout the state; expediting the flow of information from local parent groups to and from the DSHN and the EI Interagency Coordinating Council, facilitating involvement of family members in ICC Committees and other groups; dissemination of resource materials and a monthly statewide newsletter. • Annual statewide conference for parents. In FY01, sponsorship will expand from Family TIES, FCSN (Federation for Children with Special Needs), and PAL (Parent Advocacy League) to also include Families Organizing for Change, a grassroots organization promoting flexible funding and support which began with links to families with children with mental retardation. The search is on for a reasonably priced site large enough to handle the expected audience. This major event now will reach families of children of all ages with the full range of special needs: physical, medical, cognitive, educational, developmental, and behavioral.. • The Web site [http://www.massfamilyties.org] continues to provide parents and providers with up-to-date information on services, supports and personal experiences from early intervention through the transition into adult services. New features include a “Question of the Week” and direct E-mail linkages to all the regional parent coordinators. An Early Intervention web site will also be available. • Parent to Parent Support - Parent to Parent Matching System. This computerized data base system for individual parent to parent matching will be continued, in close collaboration with other disability service organizations and the Federation for Children with Special Needs. • The revised Family TIES Resource Directory for Parents with Children with Special Needs is available on the web site and will be searchable early in FY01. • Early Intervention Parent Leadership Resources Manual (a handbook for Early Intervention parents and providers) will both be revised and updated. • Early Intervention Program Re-certification. A model for including parents on the monitoring teams for EI program re-certifications is still under development; it will include staff training on the role of families as advisors and parent-to-parent interviewing on service satisfaction. • Emergency Medical Services. An evaluation of the unique emergency medical service needs and issues faced by families with children with special health care needs was done as part of the EMS-C grant through parent-to-parent interviews. The results of this survey are being used to develop strategies for improved public awareness and enhanced access and service coordination for families and to propose changes in EMS regulations. 	<p>E, I</p>

NPM #15 – The rate (per 100,000) of suicide deaths among youths 15-19.

Population(s): () Pregnant Women, Mothers and Infants (**X**) Children () CSHCN

The BFCH has identified both mental health and suicide as a major priority need area. Prevention efforts will be integrated within all appropriate programs including CSHCN, school services, gay and lesbian youth initiatives, primary care, teen parent home visiting, and related youth activities.

TABLE NPM-15C
Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
Injury Prevention – Suicide Prevention <ul style="list-style-type: none"> Finalize and disseminate the Fact Book on suicide across the life span. Transfer print material onto the Violence Prevention Task Force website Start Suicide Prevention listserv Produce and disseminate a data book on suicides in Massachusetts Continue outreach to suicide prevention practitioners Continue to move forward with the statewide planning process initiated in FY2000 Continue regular meetings of the Suicide Prevention Work Group Sponsor a State House event on suicide prevention 	P, I
School Health Services / Enhanced School Health <ul style="list-style-type: none"> During the next 2 years, the School Health Program plans to update the 600-page <i>Comprehensive School Health Manual</i>. There will be a section on teen depression and suicide. 	P
School-Based Health Centers <ul style="list-style-type: none"> Expanding program sites: In 2001, the Bureau is funding an additional 24 new SBHC sites. DPH standards require funded School-Based Health Centers to provide mental health services directly or through arrangement. Programs perform behavioral risk assessments that include emotional health risk factors. 	D, E
Office of Adolescent and Youth Development	I
State Office of Rural Health <ul style="list-style-type: none"> Assess the scope and nature of suicide in rural areas by: widely distributing copies of the recent national report on the high rate of suicide in rural areas, conducting data analyses and gathering key-informant information on suicide in rural Massachusetts, and recommending rural representatives on any new DPH task force on suicide that is formed 	I
Mental Health Promotion <ul style="list-style-type: none"> New initiatives involving the BFCH, DPH, and external organizations and programs are planned beginning in FY01. See new Priority Need #9. 	I
<i>See also discussion in the Needs Assessment regarding suicide, and in Table PN-12 on Sexual Assault Prevention and Survivor Services.</i>	

NPM #16 – Percent of very low birth weight live births.

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

Massachusetts has demonstrated successes in reducing infant mortality but is confronted with a growing rate of very low birth weight births. The BFCH recognizes the need to continue to support and enhance all current efforts to reduce both mortality and morbidity as well as to increase the focus on the health of pregnant women, mothers, fathers, families and communities. A priority will be on identifying and addressing those factors that need to be addressed and considered before pregnancy occurs. This will include issues related to fertility treatments, chronic disease, nutrition, smoking, substance use, violence, and infections. It requires coordination with women's health programs providing services outside of the reproductive period as well as greater focus on prevention and development of healthy behaviors from childhood on (see State Priority Need #1).

TABLE NPM-16C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Healthy Start Program</p> <ul style="list-style-type: none"> In an effort to ensure adequacy of prenatal care and improve quality of care Healthy Start will modify its program to include case management in the form of “trimester follow-up calls”. Each trimester call will allow Healthy Start to provide pregnant mothers with necessary health information and ensure that she has been able to access her obstetrician and is continuing and satisfied with her care and her doctor. This portion of the program will be designed in the first half of FY01 and implemented in the second half. Additional points of contact will help Healthy Start provide appropriate health education and support to pregnant women as well as modify the program in a timely manner based on input from Healthy Start members. 	E
<p>Combined Primary Care Program – Perinatal Component</p> <ul style="list-style-type: none"> Comprehensive prenatal care, outreach, case management, smoking cessation counseling, and nutrition services are provided to high risk pregnant women 	D
<p>WIC</p> <ul style="list-style-type: none"> All pregnant women receive a thorough nutrition assessment, including dietary assessment, and are prescribed an appropriate food package. In addition, pregnant women with poor weight gain patterns are monitored regularly and receive in-depth counseling and intervention plans. All pregnant women who smoke, or resume smoking during their pregnancy, are referred to smoking cessation programs. Provision and quality of nutrition services are core standards for site evaluation. 	
<p>MCH Home Visiting Program – Healthy Families (HF) and FIRSTSteps (FS)</p> <ul style="list-style-type: none"> FS programs have MCH nurses on the multidisciplinary team, which contributes to early identification, care, and coordination for high risk pregnant women. Current FS multi-disciplinary work groups are exploring the role of the nurse on the team and how to most effectively utilize this resource. This work has included surveying staff and developing nursing guidelines. Home visitors receive training to provide education to pregnant women regarding nutrition, smoking, and other prenatal health education issues, and identifying signs of pre-term labor. 	E, I
<p>ASAP Project (Alcohol Screening Assessment Project)</p> <ul style="list-style-type: none"> MCHB funded demonstration project to enhance screening and intervention for alcohol and other substance use within prenatal care. FY01 initiatives include engaging Harvard Vanguard HMO as well as Harvard Pilgrim PPO obstetric providers in training, office management and enhanced referral options for substance abuse during pregnancy. The project includes the continuation of similar FY00 initiatives with 4 community health centers and one private OB office. 	I

Programs/Activities	Pyramid
<p>Family Connection Project</p> <ul style="list-style-type: none"> New MCHB funded demonstration project to work with women of child-bearing age prior to conception on risk behavior identification and management. Three behavior areas are targeted: Alcohol and Drug Abuse, Smoking, and Unprotected Sex. Demonstration project within 2 communities provides screening of high risk women in FIRSTLink program, FOR Families, and Title X family planning, with assistance from a behavioral health case manager housed at the family planning location. Beginning in April 2001, this screening and case management will also take place at a WIC site. 	E
<p>Massachusetts Health Quality Partnership – Maternity Subgroup</p> <ul style="list-style-type: none"> Statewide collaborative of MCOs, PPOs, DMA, major hospitals, ACOG, Mass. Medical Assoc., and DPH. Subcommittee is designing a Massachusetts universal prenatal registration form that identifies risk factors for low birthweight and pre-term birth. Many of the health plans will provide case management services to members when indicated by the registration form. Data from the form will be collected centrally and utilized to better identify predictors of prematurity and low-birthweight in the Massachusetts cohort. Other MHQP activities include the ongoing development of prenatal guidelines for all MA health plans and an annual fall conference for OB and Pediatric care providers highlighting a topic related to low birthweight. 	I
<p>Multiple Birth Initiatives</p> <ul style="list-style-type: none"> In collaboration with the March of Dimes, Triplets and More Parent Group, and prenatal providers develop educational programs and other identified projects to address the complex issues related to fertility treatments and multiple births. 	I
<p>Fetal and Infant Mortality Review projects</p> <ul style="list-style-type: none"> 4 cities in MA have or are currently initiating FIMR projects. BFCH staff provide coordination, data support and technical assistance to each project as well as share best practices between projects. In FY01 BFCH will explore the institution of a statewide template FIMR which can be initiated within interested communities. 	I
<p>12th annual “Partners in Perinatal Health” Conference</p> <ul style="list-style-type: none"> In collaboration with 14 statewide perinatal advocacy and support agencies, will implement “Partners in Perinatal Health Conference,” which provides up-to-date training and multidisciplinary networking opportunities for all levels of perinatal care providers. Conference goals are to address issues impacting infant survival and women’s health, identify cultural issues affecting perinatal health care, and examine model programs that overcome barriers to optimum perinatal outcomes. This collaboration of fifteen partner organizations reaches a multidisciplinary audience of 400 providers through its annual conference. In addition, the collaboration has formed the newest state Healthy Mothers, Healthy Babies Coalition, and will, in affiliation with the National Healthy Mothers, Healthy Babies Coalition, implement a maternal and child health needs assessment in the areas of public and provider education and networking capacity. 	I
<p>Collaborative activities with DMA</p> <ul style="list-style-type: none"> On-going work with the DMA MCH managed care unit to develop strategies to increase access to prenatal care and decrease the incidence of low birthweight. Some strategies include provider and patient information in newsletters and brochures, information and reminders on routine mailings, increased communication between the enrollment section of DMA and the OB provider. 	I

NPM #17 – Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE NPM-17C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
Massachusetts Health Quality Partnership <ul style="list-style-type: none"> This statewide collaborative of MCOs, PPOs, DMA, major hospitals, ACOG, Mass. Medical Assoc., and DPH, is, among other activities, designing a Massachusetts universal prenatal registration form which identifies risk factors for low birthweight and preterm birth. Health plans would then have the ability to provide case management for identified women and, when necessary, encourage transfer to birthing facilities with neonatal units. 	I
Massachusetts Perinatal Advisory Committee <ul style="list-style-type: none"> Further systematic analysis and monitoring will be integrated into the work of the committee Further analysis of the definition of appropriate delivery site for high risk newborns (<i>see narrative in annual report Section 3.1.2.1 for further discussion of this measure</i>) 	I
Combined Primary Care Program – Perinatal Component	D, E
Surveillance	P, I

TABLE NPM-17D

Programs/Activities that Will Undergo Review or Revision

Programs/Activities	Pyramid
Review of transfer policies and practices for high risk pregnancies and deliveries, especially in the southeastern region of the state.	I

NPM #18 – Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE NPM-18C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
Healthy Start	E
Combined Primary Care Program – Perinatal Component	D, E
WIC <ul style="list-style-type: none"> <input type="checkbox"/> Prenatal women who enroll in WIC and are not receiving prenatal care are referred for such care immediately, regardless of trimester. Receipt of prenatal care is monitored at the next WIC visit. <input type="checkbox"/> Percent of women enrolled early in pregnancy is a contract performance measure. 	E
MCH Home Visiting Program – Healthy Families (HF) and FIRSTSteps (FS) <ul style="list-style-type: none"> HF has expanded to include 20 yr. olds, & is planning increased outreach in the prenatal period. 	E

Programs/Activities	Pyramid
Department of Medical Assistance MCH collaborative workgroup <ul style="list-style-type: none"> Early entry into prenatal care has been the combined effort of several DMA workgroups including their MCH MCO/PPO group, their MCH Medical Advisory Group and their Primary Care Plan-managed care group. FY01 objectives include the development of a brochure to be sent to each woman who identifies as pregnant and which includes information on getting prenatal care early in the pregnancy and gives information on finding and connecting with and OB provider. This workgroup is also exploring some of the systemic barriers clients must broach to access prenatal care, one of which is the necessity of a referral from the primary care physician. DMA is exploring strategies for PCP's to have information about a new panel member's pregnancy and giving them the encouragement to direct her to OB care immediately. 	I
12th annual "Partners in Perinatal Health" Conference <i>See Table NPM-16C</i>	I

TABLE NPM-18D

Programs/Activities that Will Undergo Review or Revision

Programs/Activities	Pyramid
Refugee and Immigrant Program <ul style="list-style-type: none"> Further study and development of strategies to address issues related to seeking early prenatal care. 	I

State Performance Measures

Please note: As a result of its Five Year Needs Assessment, Massachusetts dropped two State Performance Measures (SPM #01 and #10) and added two new measures (SPM # 11 and #12).

SPM #01 – The percent of women in need of publicly funded contraceptive services receiving family planning and related reproductive health services through programs with MCH funding.
This measure was dropped as of July 2000.

SPM #2 – The degree to which children with special health care needs and their families have appropriate care plans in place.

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

TABLE SPM-2C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
Early Intervention <ul style="list-style-type: none"> All enrolled children and families are required to have an IFSP plan within 45 days of enrollment 	E
Growth and Nutrition Program <ul style="list-style-type: none"> All children receive health care management relating to nutrition improvement for FTT. Linkages are made to a medical home and other social service needs 	D

Programs/Activities	Pyramid
School Health Services / Enhanced School Health <ul style="list-style-type: none"> All Enhanced School Health Service programs have a requirement that children with special health care needs who need treatment services in the school must have an individual health care plan. In addition, all children who receive prescription medications during the school day must have a medication administration plan. The data regarding these plans are included in the monthly activities reportable to the Department. In addition, plans are reviewed during site visits to monitor the programs. 	D, E
MassCARE	E

TABLE SPM-2D
Programs/Activities that Will Undergo Review or Revision

Programs/Activities	Pyramid
Family And Community Support <ul style="list-style-type: none"> Over the next year, with a new director, this program will shift from a freestanding model, to a model housed in medical home. The Bureau will issue an RFR (or design another approach to identify physicians who are interested and able to house a case manager), change the name to "Special Care Coordinator," and outstation in physicians' offices and hospital clinics. We will track involvement with specific families, but all CSHCN in the practice will be potential cases. We will also seek to provide much more training and information to other MD offices on how to meet the needs of CSHCN and their families. Through this change, and continued expansion of family-to-family, the Bureau aims to reach a much higher percentage of CSHCN. 	E

SPM #3 – Percent of children and youth enrolled in Medicaid, CMSP, or Title XXI who receive any preventive (well-child) services annually.

Population(s) served: () Pregnant Women, Mothers and Infants (X) Children () CSHCN

TABLE SPM-3C
Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
CMSP <ul style="list-style-type: none"> Providers will continue to receive information pertaining to the use of EPSDT guidelines for CMSP members. Most CMSP providers are also MassHealth providers. CMSP anticipates implementing a modified Primary Care Provider program for its members and network providers, expected to begin in the last six months of FY01. Members will be encouraged to sign-up with a PCP. It will be expected that the PCP will coordinate and encourage the use of applicable preventive services for members. Implementation of a PCP model is expected to increase this percentage in the first year to 30-35% of members. 	E
Combined Primary Care Program <ul style="list-style-type: none"> Timely EPSDT services are included in the site visit tool for program performance evaluation. Work with the New Bedford CHNA to assist eligible, uninsured children and families to access public health insurance, maintain coverage, and access preventive and primary health care services. The CHNA is implementing a pilot project in one classroom and one board of health, with plans to expand the project into a broader activity as best practices are identified. 	D, E
School-Based Health Centers <ul style="list-style-type: none"> Expanding program sites: In 2001, the Bureau is funding an additional 24 new SBHC sites. 	D, E

Programs/Activities	Pyramid
School Health Services / Enhanced School Health	D, E
WIC <ul style="list-style-type: none"> Assessment for and referral to on-going health care are provided at all child certification and re-certification appointments. This is a core standard for site evaluation. Information on Medicaid, CMSP, and Title XXI is provided to families of all enrolled children. Require evidence of immunization and preventive medical care Medical Advisory Board provides contacts and advice on how to increase enrollment in 3rd party programs for preventive services 	E
MCH Home Visiting Program – Healthy Families (HF) and FIRSTSteps (FS) <ul style="list-style-type: none"> Home visitors educate enrolled families about the importance of primary preventive health care, and assist parents with any barriers to well-child care for their children, including transportation. 	E
FOR Families <ul style="list-style-type: none"> As part of program services, refer all children and youth to primary health care providers, if they are not already linked to one. 	E
Early Intervention <ul style="list-style-type: none"> Families of enrolled children are assisted with barriers to access to care Referrals routinely made to primary and specialty health care providers as needed 	E
“Growing Up Healthy” (child health diary) <ul style="list-style-type: none"> “Growing Up Healthy/Creciendo Sano/Crescer Saudável” will be distributed in English, Spanish and Portuguese universally through birthing hospitals to ensure age-appropriate access to and utilization of primary care, as well as enhanced health supervision and content of care based on national Bright Futures Guidelines. Health insurance access is addressed in 3 pages and a comprehensive list of resources is provided. The core section details the 15 recommended well-child visits providing parents with the rationale and motivation to utilize preventive services from birth through age 6. 	P, I
State Office of Rural Health <ul style="list-style-type: none"> Continue to serve on the advisory group and provide technical support to <i>Moving Beyond Enrollment</i>, a federally-funded Rural Health Outreach Grant focused on developing rural models for increased enrollment in publicly-funded health insurance programs and the utilization of preventive health services. Assist with disseminating information about the state and federal <i>Bright Futures Campaigns</i> to rural hospitals, pediatric primary care providers, and community health workers in the state through targeted meetings, information in rural newsletters, and direct mailings. Support efforts to increase enrollment in health plans and utilization of preventive health services in rural areas by <ul style="list-style-type: none"> developing a session on effective rural outreach and enrollment at the annual Rural Health RoundTable Conference continuing to coordinate with rural providers and MassHealth, CMSP, and Free Care Pool state agency staff on rural issues distributing information on program and policy developments, rural strategies, and funding opportunities to a wide network of rural providers and community groups providing technical assistance to rural providers on their enrollment and utilization efforts serving on the National Association of State Offices of Rural Health SCHIP Committee. 	I
MaxCare	I
Mass. Bright Futures Initiative	P, I
Growth and Nutrition Program	D
Family and Community Support	E

Programs/Activities	Pyramid
<p>CMSP</p> <ul style="list-style-type: none"> FY01 will be the first full year that dental benefits were added to services available to CMSP members. The provider network, managed by DPH vendor will provide all information related to CMSP dental quality assurance and clinical outcomes expected. Provider and member education will be the priority the first 6 month of this program. We will work with the network, as well as with the oral health commission in establishing a percentage expected to receive preventive visits. We will also work closely with our medical provider network when a modified primary care model is implemented. This will ensure that members are properly screened for and services provided for dental needs and preventive care. 	<p>E, I</p>
<p>School Health Services / Enhanced School Health</p> <ul style="list-style-type: none"> School health service programs need to increase their focus on the oral health of children. The School Health Program will support this in the following ways: <ul style="list-style-type: none"> ➤ See NPM #7 for discussion of the need for an oral health plan by Year 2 of the Enhanced School Health Service grants. ➤ The University of Massachusetts/Simmons College will focus on oral health by: ➤ Providing a session on assessing the child's oral health needs during the Summer Institute ➤ Providing several regional programs focussing specifically on oral health during the 2000-2001 school year. 	<p>P, I</p>
<p>School-Based Health Center</p> <ul style="list-style-type: none"> In 2001 the Bureau is funding special projects in one high school and one middle school focusing on oral hygiene. In 2001, the School Health Services and School-Based Health Center programs plan to hire a dental hygienist to work with school health and School-Based Health Center staff to develop programs and educational materials focused on oral health. 	<p>D, I</p>
<p>Combined Primary Care Program</p> <ul style="list-style-type: none"> Increase Community Health Center capacity and expand dental clinics. 	<p>D</p>
<p>FOR Families</p> <ul style="list-style-type: none"> As part of program services, refer all children and youth to preventive dental services. 	<p>E</p>
<p>MCH Home Visiting Program</p> <ul style="list-style-type: none"> Provide education and referrals to dental services for enrolled toddlers and other children in family 	<p>E</p>
<p>Primary Care Cooperative Agreement</p>	
<p>“Growing Up Healthy” (child health diary)</p> <ul style="list-style-type: none"> “Growing Up Healthy/Creciendo Sano/Crescer Saudável”, the child health diary, will be distributed in English, Spanish and Portuguese universally through birthing hospitals to ensure age-appropriate access to and utilization of primary care, as well as to ensure age-appropriate, enhanced health supervision and content of care based on national Bright Futures Guidelines. Three full pages address preventive oral health for children from birth through age 6 and assist parents in finding dental care services accepting Medicaid 	<p>P, I</p>
<p>WIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> Colorful child toothbrushes and dental health education materials are provided to all enrolled children. <input type="checkbox"/> Dental health education is provided through special group education 	<p>E</p>

SPM #5 – The percent of women who report not smoking during their current pregnancy.

Population(s) served: (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE SPM-5C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Combined Primary Care Programs – Perinatal</p> <ul style="list-style-type: none"> This is a contract performance measure for the programs. 	E
<p>Primary Care Nutrition Services</p> <ul style="list-style-type: none"> Primary Care Nutritionist will continue to serve as advisor on the Quit Together Perinatal Smoking Cessation grant, which is offered at 3 demonstration WIC programs 	I
<p>MCH Home Visiting Program</p> <ul style="list-style-type: none"> Home visitors provide education on smoking and environmental smoke risks and referrals to smoking cessation programs for women and family members, as indicated. There is a performance measure on educating women who are pregnant about smoking and other substance use. Work is in progress to develop a consistent screening/assessment tool that will gather this information in a more standardized manner across all program sites. 	E
<p>Massachusetts Tobacco Control Program (MTCP) Perinatal Initiatives</p> <p>This comprehensive program has several perinatal objectives for FY01:</p> <ul style="list-style-type: none"> The development of a Spanish/English magazine for Latina pregnant women who smoke. The revision and distribution of materials in relapse to smoking prevention for postpartum women. Participation in a Perinatal Region 1 collaborative with state tobacco coordinators MCOs and PPOs to determine region-wide strategies for tobacco cessation. One product expected in FY01 is prenatal provider guidance with resources for referral and technical assistance. Increased provision of case finding and smoking cessation efforts for pregnant and parenting women within medical settings, community organizations and WIC. Increased collaboration with the MTCP media campaign to increase sensitivity to women, particularly women of childbearing age. This is done through the Women, Girls and Tobacco oversight committee of MTCP. Continued participation in the Boston Baby Faire, providing tobacco information and counseling to 1000 pregnant and parenting families. Continued local MTCP efforts at community events, such as community baby showers and health fairs, providing education materials and incentives for participants. Increased advertising and utilization of the Smoker’s Quit Line through advertisement and provider outreach. 	E, I

Programs/Activities	Pyramid
Family Connection Project <ul style="list-style-type: none"> New MCHB funded demonstration project to work with women of childbearing age prior to conception on risk behavior identification and management. Three behavior areas are targeted: Alcohol and Drug Abuse, Smoking and Unprotected Sex. Demonstration project within 2 communities provides screening of high risk women in FIRSTLink program, FOR Families, and Title X family planning with assistance from a behavioral health case manager housed at the family planning location. Beginning in April 2001, this screening and case management will also take place at a WIC site. 	E
WIC <ul style="list-style-type: none"> All women enrolled in WIC and parents/guardians of children on WIC who smoke are referred to smoking cessation programs. Six local WIC programs (3 experimental; 3 controls) continued to participate in a study with the University of Massachusetts Medical Center to develop a strategy to 'institutionalize' smoking cessation assessment, readiness to quit, and referral to cessation programs with all providers involved in prenatal care in community health centers. Materials are reviewed and revised to reflect project evaluation for statewide implementation. 	E
Healthy Start	E

SPM #6 – The rate (per 1,000) of chlamydia cases among females aged 15-19.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children () CSHCN

Note: This performance measure has been modified to report the rate *per 1000* females aged 15-19, to match the developmental health status indicator.

TABLE SPM-6C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
Family Planning <ul style="list-style-type: none"> Program monitoring, site visits and technical assistance, including medical record reviews, to contracted family planning agencies to ensure compliance with specific STD program standards and Department requirements. Ongoing participation of 5 family planning agencies with CDC Infertility Project (Chlamydia Project) which provides funding for universal Chlamydia screening. Collaboration with STD Division to provide additional funding for Chlamydia treatment for Chlamydia Project participants via family planning contracts. Ongoing participation on MDPH's STD Women's Advisory Committee. Expand access to Chlamydia screening by adding urine screening to panel of allowable services. Initiation of training needs assessment with family planning service providers, including assessment of training needs on STD service provision. Explore and develop strategies for family planning promotion, including STD information. Implementation of initiatives pending additional state funding. 	D, I
Family Connections Project <ul style="list-style-type: none"> Project works with all women of childbearing age to identify women and girls having unprotected sex, to counsel them and assist them with other behavioral health needs, particularly substance use. 	E

Programs/Activities	Pyramid
School-Based Health Center <ul style="list-style-type: none"> • Expanding program sites: In 2001, the Bureau is funding an additional 10 new SBHC sites serving this age group. In addition to providing anticipatory guidance, clinical staff assesses and counsels students at risk for STDs. • Each funded high school site has a performance measure that 1) requires that at least 85% of registered users be assessed for sexuality risk factors and 2) requires that 100% of the students determined to be a risk for STD be counseled on means to avoid STDs. As clinically indicated, School-Based Health Center clinicians screen female students for chlamydia. 	D, E
MCH Home Visiting Programs	E
Challenge Fund <i>See planned activities in Table NPM-6C</i>	E
Abstinence Education Campaign <i>See planned activities in Table NPM-6C</i>	E
Violence Prevention and Intervention Services	E
Office of Adolescent and Youth Development <ul style="list-style-type: none"> • Multiple initiatives focused on reducing adolescent risk-taking behaviors 	I, E
Combined Primary Care Programs	
CMSP	

SPM #7 – The degree to which the State assures that childcare providers have access to qualified childcare health consultants.

Population(s) served: () Pregnant Women, Mothers and Infants (X) Children () CSHCN

TABLE NPM-7C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Max Care: Maximizing the Health and Safety of Children in Out-of-Home Care</p> <ul style="list-style-type: none"> • Issue an RFR for the development of a curriculum based on the National Training Institute for Child Care Health Consultants. Two pilot sessions will reach at least 250 professionals, which is approximately 10% of the total number of health consultants in the state in Year One. The pilot trainings will be evaluated for usefulness and format at the end of Year One. Appropriate modifications will be made for the subsequent sessions. 500 additional health professionals will be reached in four sessions per year conducted in Years Two and Three. The DPH funded UMASS-Simmons School Health Institute has agreed to sponsor one of the sessions. The second session will be sponsored by the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP). Continuing medical and nursing education credits will be awarded for both sessions. • Issue another RFR for successful community-based projects to assist with the start-up of child care health consultation systems in new communities. DPH will also expand the role of the regional school health nurses to include consultation to child care health consultants. Finally, the project will increase the visibility among pediatric health professionals of Max Care and Healthy Child Care America in state professional medical associations. • Work with licensing and contracting staff and the Family Child Care Affiliates (an organization of the state's systems providers) and the USDA food sponsor programs to develop two new regulations and standards for child care health consultants. One will establish a minimum number of hours of on-site consultation. The second will require family child care systems and food sponsor programs to ensure health consultation to family child care providers. • Provide 25 training opportunities to child care entities on health and safety topics. Develop and disseminate educational materials on child care health and safety Identify existing, and create new tools, for collecting child care health and safety data • Develop and issue a set of standards of care based on the National Performance Standards for Health and Safety. 	<p>I</p>

SPM #8 – The degree to which the State assures nutrition screening and education, with referrals to nutrition assessment, counseling, and services are available to pregnant women, children and adolescents.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children () CSHCN

Note: This performance measure has been re-worded and the checklist revised to more accurately reflect components of the Bureau’s systematic approach to providing nutrition services in all its MCH programs.

TABLE SPM-8C
Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Combined Primary Care Program Nutrition Services</p> <ul style="list-style-type: none"> • Continue to provide technical assistance to CPCP contractors on meeting contract specifications and program guidelines. These conditions and guidelines include jointly developed local WIC and CPCP agreements regarding case assignment, referral and follow-up procedures and other important communication issues to ensure complete and non-duplicative nutrition services. • Participate with CPCP staff on contract monitoring of perinatal, pediatric and adolescent nutrition services. • Participate with CPCP staff in providing TA to contract sites in response to site visits and contract monitoring. Discussion with CHC nutritionists during quarterly in-service training. • Primary Care Nutritionist will collaborate with PNSS working group to 1) assure that nutrition parameters and data are consistent, and 2) develop food security and physical activity questions as part of intake of children and pregnant women served within Primary Care programs • Continue to disseminate the current <i>Nutrition Resources for Children and Their Families</i> and ongoing dissemination of state of art nutrition education materials to CPCP and/or CHC nutritionists to use with clients • Implement annual survey to CPCP and/or CHC nutritionists to identify major TA and training needs, in coordination with the WIC program Division. • Develop and implement quarterly in-service education for CHC nutritionists • Continue to represent the CPC program on the WIC Advisory Board to integrate latest policies and procedures on screening and assessment; and education between WIC and MCH • Continue to participate in the biannual meetings of the New England Nutritionists for Children with Special Health Care Needs meetings to discuss integration of nutrition services into primary care and specialty nutrition networks within Massachusetts and the NE Region • Evaluate the effectiveness of use of nutrition videoconferences in community based settings as a way to provide local training to providers of primary care and other community based nutrition services 	<p>I</p>
<p>WIC</p> <ul style="list-style-type: none"> • Collects, analyzes and reports data and trends for PNSS and PedNSS on children and women enrolled in WIC and Primary Care • WIC nutritionists work closely with Primary care and Bureau-wide projects, including special nutrition issues, such as obesity, and joint contracts. • Develops and provides nutrition education materials to the Combined Primary Care Program for community use. • Collects and reports information on physical activity and food security for enrolled women and children • Develops and provides in-service education for MCH and WIC staff • Administers the WIC Advisory Board and the WIC Medical Advisory Board, that provide input and community liaison in nutrition and nutrition services issues. • Provision and quality of nutrition services are a contract performance measure • Initiate increased focus on obesity. 	<p>E</p>

Programs/Activities	Pyramid
<p>School Based Health Centers</p> <ul style="list-style-type: none"> • Expanding program sites: In 2001, the Bureau is funding an additional 13 new SBHC sites serving elementary school age groups. Funded SBHC sites that serve elementary school aged children provide ongoing health education, counseling/support and prevention services during student visits to the SBHC. In addition to providing anticipatory guidance, clinical staff assesses and counsels students at risk for nutritional problems. • Each funded elementary school site has a performance measure that 1) requires that at least 85% of registered users be assessed for nutrition risk factors and 2) requires that 100% of the students determined to be at risk for nutrition problems (overweight or underweight) be counseled. • As part of the Department's data collection system, children with Body Mass Index (BMI) outside the normal range are flagged in the system and the SBHC is notified. • In addition in 2001, the Bureau is funding special projects on nutrition and fitness in 13 school sites. 	E
<p>School Health Services / Enhanced School Health</p> <ul style="list-style-type: none"> • The School Health Program requires the following of the 77 Enhanced School Health Service Programs: <ul style="list-style-type: none"> ➤ A student health needs assessment, including oral health and nutritional assessments, conducted at regular intervals. (It may include community health information from MassCHIP) ➤ A protocol for nutrition screening, referral and follow-up for high risk students (e.g., students with special health care needs; those who are obese, underweight, follow a vegetarian diet, or have other related issues such as eating disorders; students living in impoverished conditions with limited access to nutritionally adequate food; and students who abuse substances such as food, drugs, alcohol and tobacco). ➤ Identification and establishment of a system for developing a school environment and policies which promote healthy eating and physical activity behaviors through (a) bringing nutrition and physical activity programs and services into the school and (b) reviewing school policies on vending machines, and foods available as part of school events, etc. (Schools should use the health assessment survey as a guide and obtain input from a team e.g., health educator, consumer and food science, food service director, physical education teacher, school nurse, etc.). • The School Health Institute will provide several regional continuing educational programs on nutrition issues during the FY 2001 school year. 	E, I
<p>MCH Home Visiting Program</p> <ul style="list-style-type: none"> • Nutritional screening is conducted with all enrolled families, and referrals are made to WIC and/or other nutritional counseling and resources as needed. 	E
<p>Family Planning</p> <ul style="list-style-type: none"> • Site visits, program monitoring and technical assistance to family planning contracted agencies to assess compliance with program standards, including specific standards on nutrition. • Ongoing distribution of folic acid informational materials. • Expand preconception health materials for clients. • Initiate needs assessment on provider training, including training needs on preconception health. • Explore further family planning promotion and collaboration with the WIC program. 	E
<p>FIRSTLink</p> <ul style="list-style-type: none"> • Home visitors screen for nutritional issues and refer to food resources, including WIC, food stamps, food pantries, and others 	E
<p>FOR Families</p> <ul style="list-style-type: none"> • Home visitors screen for nutritional needs, and make referrals and provide follow up to WIC, Project Bread other food resources and primary care for children and other family members. 	E
<p>Early Intervention</p> <ul style="list-style-type: none"> • Increase use of the nutrition screening tool to 75% of programs • Work to improve coordination and connection of identified children with appropriate nutrition related services and agencies • Increase distribution of DPH educational materials on folic acid awareness 	E

Programs/Activities	Pyramid
Growth and Nutrition <ul style="list-style-type: none"> • Work to improve service coordination with referring agencies 	D
Healthy Start	E
“Growing Up Healthy” (child health diary) <ul style="list-style-type: none"> • “Growing Up Healthy/Creciendo Sano/Crescer Saudável”, the child health diary, will be distributed in English, Spanish and Portuguese universally through birthing hospitals to ensure age-appropriate access to and utilization of primary care, as well as to ensure age-appropriate, enhanced health supervision and content of care based on national Bright Futures Guidelines. More than 20 pages detail nutrition information for women and children. All materials are consistent with those used by the WIC program. WIC nutrition counselors utilize the child health diary in sessions with participants prenatally, postpartum and through age 5. 	P, I
CMSP <ul style="list-style-type: none"> • Covers any necessary nutritional services. CMSP providers are encouraged to utilize the same nutritional guidelines that are established as a part of Medicaid EPSDT program requirements. Families are referred to WIC program. Implementation of the modified primary care model in the second half of FY01 will further impact that guidelines related to nutrition assessment and services will be implemented on behalf of CMSP members. The more use of EPSDT services will directly impact access to nutritional services. 	E
State Office of Rural Health <ul style="list-style-type: none"> • Will work collaboratively with community based groups and state programs to monitor needs, provide information and technical assistance on, and develop strategies to address the new emerging concerns of hunger and food security in rural areas of the state 	I
MassMoves <ul style="list-style-type: none"> • This campaign’s goals are to provide education on the importance of physical activity, to increase physical activity, and to foster collaboration among organizations that promote physical activity and health. Activities planned for FY01 include: <ul style="list-style-type: none"> ➢ Develop an awareness campaign and a communications plan to disseminate information ➢ Develop strategies to increase access to school physical activity facilities, increase the proportion of worksites offering physical activity programs, and improve the quality and quantity of physical education in the schools, according to NASPE guidelines ➢ Identify and recruit partners to participate in MassMoves 	P, I
Osteoporosis Awareness Program <ul style="list-style-type: none"> • Develop new curriculum, teachers manual and evaluation form for the Healthy Bones Program, an educational program for third grade on bone health. • Eight schools will receive the live theatrical performance called “This is Your Life”. Focusing on nutrition, fitness, and osteoporosis prevention for middle and high school students. • Will distribute brochures, and posters emphasizing the importance of calcium, nutrition and physical activity for adolescent girls, and a shopping list to young moms assisting them in choosing calcium rich foods. • Will continue to distribute the “Osteoporosis, Are You at Risk?” handout. This handout provides basic information on risk factors, sources of calcium, nutrition, calcium supplements, smoking and osteoporosis • The Osteoporosis Education Guide will be updated and include an updated section on youth and osteoporosis, as well as a section for young women. • Osteoporosis Awareness Month will feature events for young women and adolescents as well as the older populations, including a statewide media campaign • The Osteoporosis Speakers Bureau will continue to provide comprehensive training to adolescents and adults on osteoporosis prevention. 	P, I, E

SPM #9 – The degree to which there is a statewide system for early identification, referral, appropriate services, and care coordination for all at risk children from birth to age 3.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children () CSHCN

This performance measure has been revised to expand its focus from at-risk newborns to the system of services for all at risk children birth to age three. This expanded focus is congruent with the State’s Priority Need # 5, and is also a special focus of the Bureau’s Strategic Planning Process currently taking place. The Bureau has a number of programs and services for the birth to three population, including Primary Care, WIC, FIRSTLink, FIRSTSteps and Healthy Families Home Visiting programs, Early Intervention, Growth and Nutrition, and other specialized services for CSHCN in this age group. While significant effort to coordinate these services has been made, services are not integrated to the optimal extent on many levels, from program standards, referral flow, screening protocols, provider training and technical assistance, performance measures, and especially data linkage. In addition, there has been a significant and continuing expansion in state and federal funding for other services for the birth to three population in Massachusetts, including the Mass. Family Network (Department of Education), Early HeadStart, expanded child care services, and other local and private provider initiatives. The need for a coordinated and integrated system of care has never been greater. BFCH will work together with EOHS initiatives

The Bureau will complete its Strategic Planning Process in the early Fall 2000, at which time the component checklist of this measure will be completed and submitted in an amendment to this application.

TABLE SPM-9C

Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Massachusetts FIRSTLink</p> <ul style="list-style-type: none"> • Solidify the expansion undertaken in FY00, assess the effectiveness of the implementation strategy selected, modify software and service protocols as needed, and finalize plans for full statewide implementation. This significant expansion piloted key components of a statewide system, including: <ul style="list-style-type: none"> ➤ The creation of regional FIRSTLink coordinating teams of BFCH staff in the 6 regional offices to coordinate home visits to parents living in cities and towns not served by FIRSTLink community-based programs (this team brings together the Health Access program, FOR Families, Early Intervention, and Family and Community Support [CSHCN]); ➤ Establishing a statewide network of approved providers to conduct FIRSTLink home visits with parents of newborns ➤ implementing a universal consent process in the 14 participating maternity hospitals (eliminating the geographic targeting of consents to families from specific communities); ➤ offering FIRSTLink services and information to all parents who sign FIRSTLink consent forms, regardless of individual risk status; ➤ continuing to use community-based FIRSTLink teams to coordinate home visits to families living in their service areas <p>Specific activities in FY01 will include:</p> <ul style="list-style-type: none"> • Develop mechanisms to evaluate the effectiveness of FIRSTLink’s referral system for identifying and linking at-risk families to needed health care and community services • Monitor the outcomes of FIRSTLink home visits and referrals by conducting a survey at regular intervals of parents who have received FIRSTLink services and by conducting an outcome review for families referred to other MDPH programs/services such as Early Intervention, Healthy Families and WIC programs • Hold two statewide meetings of community partners and the MDPH regional office staff to share experiences, identify needed changes, training and support • Develop new prenatal and post-natal parent education packets • Further expand services by initiating the consent process in a minimum of 5 more hospitals, and modify the screening criteria to include results of the newly instituted newborn hearing screening and implement appropriate response protocols for infants who did not pass and those who were missed 	<p>P, I, E</p>

Programs/Activities	Pyramid
Early Intervention <ul style="list-style-type: none"> • EI specialists in regional offices participate in FIRSTLink coordinating team (see discussion under FIRSTLink) • EI system is preparing for the potentially significant increase in the number of referred infants, due to the FIRSTLink expansion • DPH staff will increase by 3 individuals, to strengthen the infrastructure and support to the local programs 	E, I
MCH Home Visiting Programs	E
FOR Families - Teen Program	E
Combined Primary Care Programs	D
WIC	E
Universal Newborn Hearing Screening	P
NE Regional Newborn Screening Program	P
Massachusetts Birth Defects Monitoring Program	P, I

TABLE SPM-9D

Programs/Activities that Will Undergo Review or Revision

Programs/Activities	Pyramid
Strategic Planning for programs that serve the 0-3 population <ul style="list-style-type: none"> • Within the context of the Bureau's strategic planning process, a special focus will be on the range and scope of the 0-3 programs, with the goal of improving linkages and service provision, and avoiding duplication. 	I
MCH Home Visiting – FIRSTSteps <ul style="list-style-type: none"> • Without increased funding, this program cannot expand to serve the identified need. Continued study of the service delivery model, funding levels and structure will occur as part of the strategic planning process and on-going program development 	I
Massachusetts Birth Defects Monitoring Program <ul style="list-style-type: none"> • At this time, the birth defects monitoring system is not directly connected to a specific program. It is anticipated that the data from this system will be used to validate that children needing services in fact receiving them. • The current data base system is in need of redevelopment so that data entry may be streamlined and data maintenance stabilized. • Current legislation restricts reporting sources to hospitals. A bill introduced by the March of Dimes will expand reporting to include physicians, expands ascertainment up to 3 years of age, and empowers regulation by MDPH for data usage and confidentiality protection 	I

SPM #10 – The (a) selection or development and (b) utilization of reliable and easily measurable indicator(s) to track the management of childhood asthma. *This measure was dropped as of July, 2000.*

SPM #11– The percentage of pregnancies that are intended.

Population(s) served: (X) Pregnant Women, Mothers and Infants () Children () CSHCN
 (X) Other – Women of childbearing age

This new state performance measure has been added based on the potential impact of unintended pregnancy on the health and well-being of women, their children and families (*see additional discussion in the Needs Assessment, Section 3.1.2.1*).

TABLE SPM-11C
Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Family Planning</p> <ul style="list-style-type: none"> • Site visits, program monitoring and technical assistance to family planning agencies to ensure compliance with program standards. • Ongoing clinical service provision to families in need through statewide system of family planning agencies. Services include comprehensive exams, pregnancy testing and options counseling, counseling on reproductive health issues, contraceptive provision including access to emergency contraception, STD counseling, testing, diagnosis and treatment and HIV prevention and education, and referrals to related services such as primary care. • Expansion of service sites to reach those at greatest need, pending funding availability. • Ongoing collaboration with Keep Teens Healthy, a Medicaid sponsored program providing family planning outreach to high risk teens. • Ongoing collaboration with the Challenge Fund, a statewide teen pregnancy prevention program. • Initiation of training needs assessment with family planning service providers, including assessing needs for training on issues related to improving access to services to those at highest risk for unintended pregnancy. • Ongoing Specialized and Enhanced Outreach strategies and activities targeted to at risk clients. Pending additional state funding, these initiatives will be expanded in fiscal year 2001. • Collaboration with Women’s Health Network to provide family planning information and referral through an 800 number. Initiated in 2000 and ongoing in 2001. Possible expansion with additional funding. • In collaboration with the Massachusetts Medical Society, promotion of emergency contraception through a statewide education campaign with clinicians. • Explore and develop other strategies/campaigns for the prevention of unintended pregnancy and promotion of family planning such as newsletters, radio, and PSAs, including strategies specific to those at highest risk. Initiation of new strategies contingent upon additional state funding. Include collaboration with key MDPH programs such as violence prevention, STD, HIV, and primary care. • Initiate needs assessment on provider training, including training needs on unintended pregnancy and preconception health. 	<p>D, E, I</p>
<p>Challenge Fund – Teen Pregnancy Prevention</p>	<p>E, P</p>
<p>Office of Adolescent and Youth Development</p>	<p>I, E</p>

Programs/Activities	Pyramid
<p>Combined Primary Care Program</p> <ul style="list-style-type: none"> Contracted sites have a performance measure that requires service providers to ask women about family planning and to make referrals to a local family planning program, if the CPCP site does not provide the service directly. 	D, E
<p>MCH Home Visiting Programs</p> <ul style="list-style-type: none"> Home visitors offer family planning information and routinely refer enrolled women to local family planning programs. Home visitors in some sites have completed special training and are certified family planning counselors. 	E
<p>FOR Families</p> <ul style="list-style-type: none"> Home visitors offer family planning information and refer women to local family planning programs as indicated. 	E
<p>WIC</p> <ul style="list-style-type: none"> Enrolled postpartum women and mothers of enrolled children are referred to local family planning programs. 	E
<p>State Office of Rural Health (SORH)</p> <ul style="list-style-type: none"> Will continue to work with the MDPH Family Planning Program to assess needs, identify appropriate service models and opportunities that will extend family planning services out into the underserved more remote and rural areas of the state. 	I
<p>Violence Prevention and Intervention Services</p> <ul style="list-style-type: none"> Rape Crisis Centers offer teen dating violence prevention education and services that include information about family planning. 	E

SPM #12 – The degree to which the State has developed and implemented comprehensive education, screening, and referral protocols for violence against women and children

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children (X) CSHCN

As a result of the Needs Assessment, this state performance was added as of July 2000.

TABLE SPM-12C
Programs/Activities that are New or Will Continue

Programs/Activities	Pyramid
<p>Violence Prevention and Intervention Unit</p> <ul style="list-style-type: none"> • Development of formalized linkage, through a collaborative working group, between MDPH Violence Prevention and Intervention Services (VPIS) and the Maternal and Child Health (MCH)-related programs. This group will discuss and refine the checklist for the components of comprehensive education, screening and referral protocols as well as provide leadership for the initiatives/activities outlined below. • <u>Working Group Membership:</u> Violence Prevention and Intervention Services includes programs that address domestic violence, sexual assault and children who witness domestic violence. A point person will be assigned from the “violence prevention team” and staff from each relevant VPIS program will participate. Programs within the Bureau of Family and Community Health that will participate in the working group include home visiting programs, primary care, perinatal and child health, children with special healthcare needs, adolescent health, family planning, and others. The working group will also seek inclusion of staff from the Bureau of Substance Abuse Services and the AIDS Bureau with the hope of fostering use of the protocols across DPH as well as the Bureau. • <u>Elements of the Protocols:</u> Because of the different settings and spectra of care offered by programs across the Bureau, a single protocol will likely not meet the needs of all programs or their patients/clients. Therefore, the working group will be charged with developing several comprehensive protocols that are tailored to the particular setting in which client contact occurs, as well as the types of services made available to patients/clients. At a minimum, the working group will develop protocols appropriate for community health center primary and perinatal care programs, home visiting programs, and pediatric care programs. Each protocol will refer to basic elements: <ul style="list-style-type: none"> ➤ patient/client education regarding violence against women and the effects on children ➤ patient/client screening (including suggestions for setting a context and types of questions used) ➤ trauma-informed patient care ➤ basics of safety planning for patients/clients ➤ provider orientation and regular update training ➤ linkages with essential community resources for referral ➤ basic safety planning for staff including the existence of specific security and safety protocols ➤ quality improvement evaluation • Development of a needs assessment and survey for community-based health centers to determine if and where screening is occurring, what resources are available within the health center that can assist with patient education and referral, and what education and referral resources are needed to more appropriately respond to potential victims of violence. This needs assessment and survey will result in a report that will both provide an analysis of what is currently happening with respect to responding to violence against women and children in health care settings as well as provide valuable information regarding what is needed to more appropriately respond. • Provide an informational conference for health care providers on working strategies for protocol development and implementation based upon the report of the needs assessment and survey and the work of the MCH/VPIS working group. • Development of a plan to prioritize Bureau programs for technical assistance in development and implementation of a comprehensive protocol • Identification of training opportunities that will bring together violence prevention providers (e.g. rape crisis centers, programs addressing violence against women in immigrant/refugee communities, 	<p>I, E</p>

Programs/Activities	Pyramid
<p>rural domestic violence and child victimization project providers, etc.) with MC&FH providers in order to establish concrete, community-based links for resources and referrals.</p> <ul style="list-style-type: none"> Establishment of a formalized linkage with the Health Care Working Group of the Governor's Commission on Domestic Violence. This state-wide working group is involved in developing recommendations for health care professionals regarding universal screening and appropriate care for victims of domestic violence. The Department's joint Violence Prevention/MC&FH working group can help assure that the needs of victims of sexual violence as well as children are included in these recommendations. 	
<p>School Health Services / Enhanced School Health</p> <ul style="list-style-type: none"> Through encouragement from the DPH, the DOE is asking the schools to collect statistics from all school health services programs on the numbers of children who present to the nurse's office with conflict-related injuries. This is a marker for the violence potential in the school. The School Health Institute will present a program for school health personnel on a wide variety of violence-related issues: (a) domestic violence, (b) date rape, (c) child abuse, etc. 	E, I
<p>School-Based Health Centers</p> <ul style="list-style-type: none"> In 2001, the Bureau is funding special projects in 3 school sites that will focus on violence prevention, anger management or relationship violence. 	E
<p>FOR Families</p> <ul style="list-style-type: none"> Include information, educational materials and referrals to women and children who are current and past victims of violence, abuse and trauma. Ensure that any women and children in situations with potential for violence are referred to appropriate services. 	E
<p>Family Planning</p> <ul style="list-style-type: none"> Site visits, program monitoring and technical assistance to provider agencies to assess compliance with program standards, including specific standards on violence screening and prevention. Initiate needs assessment on provider training, including training needs on violence screening and prevention in family planning programs. Ongoing collaboration with violence prevention programs at MDPH, including coordination of efforts on the reduction of unintended pregnancy. 	E
<p>MCH Home Visiting Program - Healthy Families (HF) and FIRSTSteps (FS)</p> <ul style="list-style-type: none"> A primary goal of both HF and FS is to decrease child abuse and neglect. Statewide training provided to all home visiting staff includes child abuse and neglect. Individual programs provide staff training on domestic violence, using local community DV related programs. This shared training facilitates collaborative relationships between the home visiting programs and the providers of domestic violence services. The data system) collects information on family violence, including child abuse and neglect. DPH staff are currently working with the DSS to develop protocols/procedures to track child abuse/neglect reports made on enrolled families (the number of substantiated reports of child abuse and neglect is a contract performance measure). DPH staff participate in the Injury Prevention Task Force (formerly the "Domestic Violence" workgroup) that crosses all Bureaus at DPH and the DSS Juvenile Justice Task Force. All home visiting staff are invited to attend a variety of Domestic Violence trainings that are offered through other DPH initiatives. 	E

Programs/Activities	Pyramid
<p>ASAP Project (Alcohol Screening Assessment Project)</p> <ul style="list-style-type: none"> MCHB funded demonstration project to enhance screening and intervention for alcohol and other substance use within prenatal care. This self-administered questionnaire also includes screening for domestic violence and other predictors of domestic violence including social isolation, depression and eating disorders. FY01 initiatives involve engaging 2 large HMO and PPO obstetric provider groups in training, office management and enhanced referral options. The project includes the continuation of similar FY00 initiatives with 4 community health centers and one private OB office. 	E
<p>Family Connection Project</p> <ul style="list-style-type: none"> New MCHB funded demonstration project to work with women of child-bearing age prior to conception on risk behavior identification and management. Three behavior areas are targeted: Alcohol and Drug Abuse, Smoking, and Unprotected Sex. Domestic violence and predictors of domestic violence such as depression, social isolation and eating disorders are also screened. This demonstration project within 2 communities provides screening of high risk women in FIRSTLink program, FOR Families, and Title X family planning with assistance, counseling and support from a behavioral health case manager housed at the family planning location. Beginning in April 2001, this screening and case management will also take place at a WIC site. 	E
<p>Combined Primary Care Program</p> <ul style="list-style-type: none"> Language is included in the CPCP site visit tool regarding assessment of patient/family for safety. Working with the New Bedford CHNA to address domestic violence issues in that community, with specific activities that include local police departments, district attorneys office, and other community agencies 	D, E
<p>“Growing Up Healthy” (child health diary)</p> <ul style="list-style-type: none"> “Growing Up Healthy/Creciendo Sano/Crescer Saudável” will be distributed in English, Spanish and Portuguese universally through birthing hospitals to ensure age-appropriate access to and utilization of primary care, as well as to ensure age-appropriate, enhanced health supervision and content of care based on national Bright Futures Guidelines. 10 pages address violence prevention, including how to get safe, discipline, stress management, identifying abuse and violence in the media. 	P, I
<p>State Office of Rural Health</p> <ul style="list-style-type: none"> Will facilitate the dissemination of screening and referral protocols to rural providers in the state through promotion at meetings and assistance with connecting DPH Office of Violence Prevention staff and resources with rural providers and community groups. 	I

Massachusetts Priority Needs

The following section contains descriptions of additional programs and activities planned for FY01 that will contribute to the selected State Priority Needs. These priorities are limited to those not already addressed in the national and/or state performance measures.

Priority Need #1: Improve pregnancy outcomes, including a focus on pre-conceptual health.

TABLE PN-1

Programs/Activities	Pyramid
<p>Healthy Start Program</p> <ul style="list-style-type: none"> • In an effort to ensure adequacy of prenatal care and improve quality of care Healthy Start will modify its program to include case management in the form of “trimester follow-up calls”. Each trimester call will allow Healthy Start to provide pregnant mothers with necessary health information and ensure that she has been able to access her obstetrician and is continuing and satisfied with her care and her doctor. This portion of the program will be designed in the first half of FY01 and implemented in the second half. Additional points of contact will help Healthy Start provide appropriate health education and support to pregnant women as well as modify the program in a timely manner based on input from Healthy Start members. 	
<p>Maternal Mortality and Morbidity Review Study</p> <p><u>Mortality</u></p> <ul style="list-style-type: none"> • Continue review of 1999 death and develop report • Complete review of social causes of maternal deaths and prepare second maternal mortality report <p><u>Morbidity</u></p> <ul style="list-style-type: none"> • Continue research on uterine rupture (UR), and begin study of the incidence of other maternal morbidities • Develop new maternal and infant health surveillance system (The Maternal, Perinatal and Infant Health Database - MPIHD) through the linkage of all 1998 births to hospital discharge records of mothers and newborns, and to infant death certificate data. • Expand linked MPIHD file with addition of fetal and maternal death certificate data. 	
<p>Continue Folic Acid Awareness activities</p>	
<p>HIV Risk Reduction</p> <ul style="list-style-type: none"> • Family Connections <ul style="list-style-type: none"> ➤ New MCHB funded demonstration project to work with women of child-bearing age prior to conception on risk behavior identification and management. Three behavior areas are targeted: Alcohol and Drug Abuse, Smoking, and Unprotected Sex. • MassCARE • Combined Primary Care Program <ul style="list-style-type: none"> ➤ Encourage all pregnant women to be screened for HIV ➤ Counseling and education on HIV risk reduction • Reconvene DPH-wide workgroup addressing the risks and risk-taking behaviors (including substance abuse, unprotected sex, domestic violence) in women of reproductive age 	

Priority Need #02: Reduce adolescent risk factors and risk-taking behaviors, including among adolescents with special health care needs.

TABLE PN-2

Programs/Activities	Pyramid
<p>School Health Services / Enhanced School Health</p> <ul style="list-style-type: none"> • Work with the University of Massachusetts Medial Center to compile feedback from focus groups of school nurses to identify individual interventions to assist students in smoking treatment/cessation. • Promote comprehensive school health education programs in the 77 Enhanced School Health Service Programs, including a focus on prevention. • Consider joint site visits with DOE staff who are monitoring the health education programs for the Health Protection Grants. • Continue to work with the SHI to train school staff in the Life Skills Program, which was evaluated by the CDC to be effective in reducing risk behaviors. 	
<p>Abstinence Education Campaign</p> <ul style="list-style-type: none"> • Continue to develop an infrastructure for expansion and growth through coordinated efforts with other existing prevention initiatives statewide • Continue to built and increase capacity for growth and development through the community advisory board and by enlisting new collaborators working with adolescents and families. • Continue to research statewide programs and agencies working on adolescents health issues • Continue to add to list of collaborators including community agencies, community centers, faith based organizations, etc. for distribution of education materials particularly relating to phase IV legislative mandates • Continue to add to list of youth serving programs for distributing teen collateral items particularly relating to phase IV Federal legislative mandates • Continue to adapt and modify new messages to reflect research findings to meet Federal legislative mandates • Continue to participate in a number of local events for teens, parents, and health educators working with families • Will continue to expand and integrate of abstinence with other youth health/wellness areas 	
<p>Teen Pregnancy Prevention Challenge Fund <i>See also planned activities in Table NPM-6C and Table SPM-10C</i></p> <ul style="list-style-type: none"> • Re-establishment of an internal cross-bureau Adolescent Health Services Committee and identify/address training needs in the areas of adolescent development • Begin development of an external advisory board to the Bureau(s) of which the membership is comprised of youth representing DPH target populations and health issues in order to provide input into policy development, program effectiveness, etc. • Development and distribution of updated Adolescent Health Services Matrix • Development and distribution of Statewide Adolescent Health Report to assess and monitor programs' success in meeting CDC 2010 Objectives and Adolescent MCH health objectives, including but not limited to access to health care, mental health, addictive behaviors, sexual health, interpersonal violence, nutrition, participation in physical activity/sports involvement, unintentional injury and special populations (i.e. adolescents with special health care needs, gay, lesbian, bisexual and transgender adolescents, out-of-school youth, homeless youth and youth with special educational needs) • Coordination of efforts with DOE in order to strengthen comprehensive school health education and develop infrastructure to support coordinated school health programs through the <i>School Health Programs to Prevent Serious Health Problems and Improve Educational Outcomes</i> initiative (if funded). 	

Programs/Activities	Pyramid
<p>State Office of Rural Health</p> <ul style="list-style-type: none"> The SORH and the MDPH Rural Health Workgroup will work with Health Addictions Research Institute (MassSNAP) and MDPH data analysts to produce data specifically for targeted rural communities that includes data on selected adolescent risk factors as well as protective factors. The SORH will continue to work with local communities to assess needs, identify potential funding and resources, and assist with the development of rural youth programs. 	
<p>DMA MCO workgroup</p> <ul style="list-style-type: none"> Selected Adolescent Anticipatory Guidance as its focused objective for FY01. Initiatives might include the production or distribution of materials for providers and teens, incentives for teens to access care, and universal, simplified guidelines for adolescent health care and counseling. 	

Priority Need #3: Improve oral health for children and youth, particularly those depending on publicly funded oral health coverage and those with special health care needs.

TABLE PN-3

Programs/Activities	Pyramid
<p>Teen Pregnancy Prevention Challenge Fund</p> <ul style="list-style-type: none"> Implementation of a minimum of 400 on-going activities serving approximately 1,500 youth and that are specifically focused on increasing youth's access to publicly funded health insurance, including oral health coverage. 	
<p>State Office of Rural Health (SORH)</p> <ul style="list-style-type: none"> Develop a session on rural oral health programs at the New England Rural Health RoundTable Annual Conference Continue to assist the MDPH Office of Oral Health with the development of dental health clinics and a full range of oral health services in rural areas of the state Regularly distribute resources and information on rural models of oral health services, funding opportunities, and updated policy and program information to a wide network of rural health providers and community groups The Office of Primary Care Systems, in collaboration with the MDPH Office of Oral Health and the MDPH SORH, will support the analyses and development of federal applications for additional dental Health Professional Shortage Area designations in the state. 	
<p>Combined Primary Care Program</p> <ul style="list-style-type: none"> Collaborate on the development and implementation of a primary care, nutrition and oral health education module for use elementary schools during national dental month Oral health activities were highlighted by the BFCH in a new RFR in FY00 to support certain special initiatives funded by the state legislature from tobacco settlement funds. Nineteen of the new contract awards included oral health activities. 	

Priority Need #4: Enhance data systems and incorporate new technologies to support MCH service provision, data management, performance measurement, and electronic service delivery in a managed care environment.

TABLE PN-4

Programs/Activities	Pyramid
<p>Contract Performance Review</p> <ul style="list-style-type: none"> BFCH has established a comprehensive process for the establishment of performance measures for each program and initiated in FY'98 a revised contract review process which incorporated the development of a uniform assessment form. This form is made contract specific in relation to program definitions, standards, measures and weights. Goals and actual performance outcomes were established for each program performance objective and contract specific measure. Programmatic concerns, agency principles, and administration were defined and rate established. Provider input was obtained in the development and the on-going refinement of the process and tools. Information provided through verbal and written communications, site visits, reports, program and client data and fiscal and administrative data are utilized by program staff in completing the review. 	
<p>Information Technology (IT) Systems</p> <ul style="list-style-type: none"> BFCH is engaged in a strategic planning process in relation to the Office of Statistics and Evaluation to address the changing and growing needs of the BFCH in relation to IT especially complex, MIS systems, internet-based systems and enhancements of existing systems. There is on going assessment and upgrading of existing data and technical systems including hardware. Operating systems and network infrastructure are reassessed annually and upgrades planned as indicated. 	
<p>Combined Primary Care Program</p> <ul style="list-style-type: none"> The CPCP has initiated preliminary discussion with relevant OSE staff to look at program data reporting with the intention of developing appropriate systems. In FY'01, it is expected that CPCP-specific staff, and CPCP-OSE staff vacant positions will be filled and assessment of what is reported, adequacy of reporting, duplicative reporting etc., will begin. This project is anticipated to be coordinated with overall BFCH data system assessment, development and evaluation, and will be a long-term, incrementally implemented project. 	
<p>School Health</p> <ul style="list-style-type: none"> All Enhanced Programs are required to submit monthly data reports; these reports focus mainly on health service activities and case management. 	
<p>Family Planning</p> <ul style="list-style-type: none"> Explore the feasibility of web-based billing and data collection through intra-agency workgroup. Compare program data to MassCHIP and BRFSS 1998 & 2000 data Put AGI data into MassCHIP, and link program data 	

Priority Need # 5: Develop and implement an integrated system for early risk identification, follow-up, referral, services, and family involvement for children ages birth to 3.

TABLE PN-5

Programs/Activities	Pyramid
<p>The Bureau's Birth to Three priority will be integrated with the EOHHS planning initiatives to achieve the Commonwealth's vision that all infants and toddlers in Massachusetts will be engaged in nurturing relationships in safe, supportive environments. This will include a strong community level effort to ensure the development of a community process that provides for identification, referral, coordination and information to the full range of services and supports for families with young children. A second component will be to work with all relevant state agencies and programs to coordinate policies and programs in developing, implementing and</p>	<p>I</p>

Programs/Activities	Pyramid
<p>managing community based programs. This effort will focus on creating a seamless system of services for any individual child and family regardless of the funding source or agency responsible. This includes expansion of the Massachusetts SIDS program to focus on deaths to all children during the first year of life.</p> <p>The BFCH's goal is to deliver needed services to children and families so that there is minimal redundancy in enrollment for services and optimal integration of service components delivered to families depending upon their needs from high technology, specialty services to enrollment in health insurance, immunization, preventive visits, and safe child care. In addition, the BFCH will take the lead within the DPH to develop an integrated data system for children from birth to five. The initial plans for this are being developed and prepared for submission to the IT team for review (see also State Performance Measure # 9).</p>	

Priority Need #06: Assess the impact of health care delivery, insurance, immigration and welfare systems changes on access to and quality of care for women, children, and youth, including CSHCN, and on MCH service programs.

TABLE PN-6

Programs/Activities	Pyramid
<p>FOR Families</p> <ul style="list-style-type: none"> Conduct follow up, outreach and referral program for families who have reached 24 month time limits for cash assistance from welfare (TANF). Families are referred by welfare agency workers, self referral through 800 I & R line. Home Visitor staff (RNs, SWs) contact families, conduct 1.5 hour home visit assessment, prioritize needs, make referrals. Home Visitors and Resource Specialists maintain periodic contact with families for 12 months, ensuring that families have MassHealth and food stamps, access to primary care, adequate food, safe housing, welfare to work services and benefits. 	
<p>SSI and Public Benefits Outreach, Training, Technical Assistance and Policy Activities</p> <ul style="list-style-type: none"> Continuing Activities regarding the Children's Health Access Coalition and sharing of updates with staff and health care providers on effects of health insurance reform and welfare reform on children with special health care needs. 	
<p>Massachusetts Initiative for Youth with Disabilities (MIYD)</p> <ul style="list-style-type: none"> Demonstration project in Franklin County: MIYD will fund two school-based after-school inclusive social/recreational programs for adolescents with disabilities in Franklin and western Worcester Counties. These programs were developed collaboratively by parents of students with disabilities and school staff. They are designed to address the issue of social isolation and lack of opportunities for inclusive socialization for youth with disabilities, especially in rural areas. Emphasis in FY01 will be on program development and expansion, documentation and evaluation. 	
<p>MCH Home Visiting</p> <ul style="list-style-type: none"> The PDS collects information regarding health access issues and economic challenges. DPH staff have the ability to analyze this data. Local Healthy Families program / agency staff work with The Alliance of Young Families, a statewide advocacy group for young families. A major focus of this group has been welfare reform's impact on teens and teen parents. Increased collaboration between DPH For Families staff and Home Visiting staff. 	
<p>State Office of Rural Health</p> <ul style="list-style-type: none"> Continue to gather and bring forward information for the Department on the needs and emerging issues due to system changes impacting rural MCH services and the health of the MCH population in rural areas from meetings and periodic broader health forums with rural providers and community groups 	

Programs/Activities	Pyramid
<ul style="list-style-type: none"> • Continue to monitor needs, work collaboratively to address, and provide information and technical assistance specifically on transportation and hunger, which have been identified as major needs in rural areas, and which can be related to changes in the health care delivery system and welfare system changes • In collaboration with the MDPH Rural Health Workgroup and data analysts from the Bureau of Health Statistics and OSE, develop community data packets for rural areas of the state and explore the option of including a standard rural health report format in MassCHIP. 	

Priority Need #07: Develop and implement initiatives that address violence against women, children and youth.

TABLE PN-7

Programs/Activities	Pyramid
<p>Teen Pregnancy Prevention Challenge Fund</p> <ul style="list-style-type: none"> • Coordination of efforts with the Sexual Assault Prevention and Survivors Support Services Program at MDPH, including participation at statewide initiatives such as the Sexual Assault Prevention and Intervention Advisory Committee (SAPIN) • Implementation of a minimum of 400 on-going activities focused on teen dating violence, serving approximately 5,000 young men and women • Implementation of a minimum of 100 on-going activities focused on domestic violence, serving approximately 500 young men and women • Implementation of a minimum of 550 one-time activities focused on teen dating violence, serving approximately 27,000 youth participants • Implementation of a minimum of 150 one-time activities focused on domestic violence, serving approximately 300 youth participants 	
<p>Abstinence Education Campaign</p> <ul style="list-style-type: none"> • Develop and broadcast 2 new Television ads targeting young males 20-24 years old and 5 Radio messages targeting youth 15 – 17 years old, young males 20 –24 years old and parents. The messages will be designed to meet the following Federal legislative mandates. They are: <ul style="list-style-type: none"> ➤ Support parents to instill positive values and set clear limits and behavioral expectations for their children ➤ Educate youth about the impact of alcohol and other substances have in relationship to sexual assault and the ability to remain abstinent ➤ Increase community awareness regarding the sexual exploitation of young females by older males • Will develop and broadcast 4 additional Radio messages for youth 15 – 17 years and parents to <ul style="list-style-type: none"> ➤ Support parents to instill positive values and set clear limits and behavioral expectations for their children ➤ Educate youth about the impact of alcohol and other substances have in relationship to sexual assault and the ability to remain abstinent 	
<p>State Office of Rural Health</p> <ul style="list-style-type: none"> • The SORH will facilitate the expansion of the Sexual Assault Nurse Examiner’s Program (SANE) to rural hospitals in the state through the Rural Hospital Flexibility Program. • The Greater Milford Area CHNA will continue it’s campaign to raise awareness about and develop collaborative approaches to address violence against women, teen dating violence, and elder and child abuse. 	

Priority need #08: Develop and implement public health programs and policies that promote positive mental health for the MCH population, and collaborate to improve access to appropriate mental health services.

TABLE PN-8

Programs/Activities	Pyramid
<p>FOR Families</p> <ul style="list-style-type: none"> • Conduct outreach and referrals to children and adolescents with mental and behavioral health issues 	
<p>Home Visiting</p> <ul style="list-style-type: none"> • FS programs have licensed mental health professionals as part of the team. All do consultation; some do visiting and evaluation. • FS programs have recently been surveyed to explore the mental health professional’s role on the team. Plans include creating a workgroup and developing consistent guidelines and procedures statewide. • Many of the HF coordinators are clinical social workers; mental health issues are addressed regularly as part of home visitor supervision and coordination. • Many of the programs are housed in agencies that provide mental health/counseling services, which enables easy access to and collaboration with mental health professionals. • All home visiting programs conduct infant and child developmental screening that includes social/emotional issues that contribute to positive mental health. • All home visiting staff regularly monitor their families’ mental health, stress management, and family relationships that might impact mental health. This information is entered into the PDS. • All program staff participate in training that includes post-partum depression. 	
<p>MCH Health Education</p> <ul style="list-style-type: none"> • Convene a task force on maternal mental health and depression to identify the incidence, etiology and impact of maternal depression on maternal and child health outcomes, and to identify preventive interventions. This task force may become a project of the Healthy Mothers, Healthy Babies Coalition of Massachusetts, which has historically included maternal depression as a focus, and may identify it as a priority as it conducts its needs assessment in FY2001. 	
<p>State Office of Rural Health</p> <ul style="list-style-type: none"> • Work with the Office of Primary Care Systems, in collaboration with the Department of Mental Health, to support the analyses and development of federal applications for additional Mental Health Professional Shortage Area designations in the state • Highlight the unique nature of mental health issues for rural communities in the following ways: <ul style="list-style-type: none"> ➤ Develop a session on rural mental health at the New England Rural Health RoundTable Annual Conference ➤ Develop a policy level staff contact for collaboration on rural needs with the Department of Mental Health ➤ Promote the newsletter, conference, and other activities of the National Association of Rural Mental Health ➤ Regularly distribute resources and information on mental health to a wide network of rural health providers and community groups 	
<p>Men’s Health Initiative</p> <ul style="list-style-type: none"> • Identify health care service gaps for men <ul style="list-style-type: none"> ➤ Conduct a survey of health care providers to assess how they currently serve males and fathers (men’s health, teen pregnancy prevention, involvement in child’s health care, etc), and what assistance (training, educational material, protocols, community service, referral) would be most useful in maximizing men’s use of health services ➤ Evaluate the availability of health services for non-custodial parents and single males 	

Programs/Activities	Pyramid
<ul style="list-style-type: none"> • Develop best practice models for health care providers on outreach strategies for men 18-24 • Increase men’s use of health services and referrals by adding male outreach workers at community health centers and school based health centers • Promote culturally sensitive father involvement courses at health centers and hospitals • Promote prevention of teen pregnancy and expand existing pregnancy prevention and abstinence outreach programs to young men • Support efforts to lower Massachusetts’ out-of-wedlock birth rate • Identify most pressing unmet health and employment needs of men on probation, parole, or soon to be released from prison. Form collaborations between these three systems to improve these men's access to health and employment services. • Identify issues related to marriage, divorce, re-marriage, cohabitation, father absence, father involvement, and voluntary acknowledgement of paternity. Identify needed data around these issues that is not being collected and work with the Office of Statistics and Evaluation to develop a fatherhood report for MassCHIP. Identify types of data that state agencies collect that can be shared among themselves, and facilitate this data sharing. • Establish a clearinghouse of information on responsible fatherhood for health care providers, including curriculum/training material for teen males, ways to get young men to take care of their health so they can be there for their children, referrals for job training, substance abuse, responsible fatherhood programs. • Consider adding male outreach workers to home visiting programs for parents in order to better connect with men and develop clear and comprehensive messages for the staff about responsible fathering. 	

Priority Need # 9: Monitor and develop strategies to address childhood health conditions that are increasing in prevalence, including asthma and obesity.

TABLE PN-9

Programs/Activities	Pyramid
<p>FOR Families</p> <ul style="list-style-type: none"> • Conduct outreach and referrals to primary and specialty care for family members with asthma and asthma like symptoms. 	
<p>SBHC</p> <ul style="list-style-type: none"> • In 2001 the Bureau is funding an asthma management special project at a school serving grades K-8. 	
<p>DSHN</p> <ul style="list-style-type: none"> • Has hired an Asthma Coordinator who will start 7/1/00. Responsibilities will include a) staffing the DPH Asthma Work Group; b) designing and carrying out a needs assessment related to asthma services in the state, and c) developing a state asthma plan based on needs assessment findings. 	
<p>Primary Care Nutrition Services</p> <ul style="list-style-type: none"> • Expand Healthy Choices program to 8 additional schools, apply for extension of CDC-NCI evaluation grant and include 4 of the new Healthy Choices schools in the evaluation. • Apply for CDC obesity grant • Explore options for implementing physical activity initiatives in schools working with MassMoves • Continue to work with 5 A Day coalition to get 5 A Day message out • Distribute a survey to schools statewide and compile a resource list of nutrition and physical activity initiatives in schools working with the School Nutrition Task Force 	
<p>MCH Home Visiting</p> <ul style="list-style-type: none"> • The PDS collects information about identified health issues and conditions of enrolled mothers and children. 	

Priority Need #10: Improve accessibility and utilization of MCH services, with emphasis on 1) cultural competency; 2) service availability in rural areas; and 3) increasing public knowledge about MCH services.

TABLE PN-10

Programs/Activities	Pyramid
<p>The Community Health Worker Network</p> <ul style="list-style-type: none"> (a new initiative funded by the MCHB CISS/COG program) Will develop and implement a statewide community health worker (CHW) system. Through the building of a sustainable infrastructure, community health workers (CHWs) will have increased capacity to address both consumer-based and systemic barriers to increased access to and utilization of preventive health care. As a result of consistent and comprehensive training and networking opportunities, CHWs will increase public awareness and knowledge of DPH services and resources for the MCH population. As bridges between health care providers and the communities they serve, CHWs improve cultural competency among health care providers and service systems by transferring knowledge about the community and informing the design of culturally competent and effective outreach and health services. Through their capacity to build trust and establish linkages in traditionally underserved and hard-to-reach communities, CHWs will improve the consistency of resources and access to services across the state, and especially in rural areas. 	
<p>MCH Health Education</p> <ul style="list-style-type: none"> Develop a Web-based version of the revised and expanded “Maternal and Child Health Education Materials: A Resource List”, increasing access for all DPH programs, DPH vendors, maternal and child health care providers, and the general public. 	
<p>FOR Families</p> <ul style="list-style-type: none"> Establish and maintain relationships with health and human service providers and keep them informed and updated as to the array of DPH services and resources. 	
<p>Family Planning</p> <ul style="list-style-type: none"> Establish staff position of Family Planning Education, Training and Outreach coordinator to promote knowledge and public awareness of family planning internally and externally. Program monitoring, site visits and technical assistance to family planning agencies, including assessment of compliance with program standards on cultural competency. Initiate needs assessment on provider training, including training needs on cultural competency. Expand service areas to areas currently under-served, specifically the communities of Marlboro and Charlestown. Participation on The Alan Guttmacher Institute Advisory Panel to provide guidance and advice for a new five year project, <i>Assessing Family Planning and Reproductive Health Services in the United States</i> Begin implementation of recommendations from Public Consulting Group report on the allocation of state family planning funding. Program monitoring, site visits and technical assistance to family planning contracted agencies to ensure consistency of resources and access to services. 	
<p>Abstinence Education Campaign</p> <ul style="list-style-type: none"> Continue to ensure educational materials and messages are culturally competent, and provide technical assistance to different initiatives Continue to assure members of community advisory group and collaborators are representative of target populations Continue assure media buy is spread across the state and serve target populations Continue to participate in a number of local events across the state Continue to develop an infrastructure for expansion and growth through coordinated efforts 	

Programs/Activities	Pyramid
<p>with other existing prevention initiatives statewide</p> <ul style="list-style-type: none"> • Continue to built and increase capacity for growth and development through the community advisory board and by enlisting new collaborators working with adolescents and families • Continue to research statewide programs and agencies working on adolescents health issues • Continue to add to list of collaborators including community agencies, community centers, faith based organizations, etc. for distribution of education materials particularly relating to phase IV legislative mandates • Continue to add to list of youth serving programs for distributing teen collateral items particularly relating to phase IV Federal legislative mandates 	
<p>MCH Home Visiting</p> <ul style="list-style-type: none"> • DPH home visiting staff regularly attend statewide meetings and other community forums where there are opportunities to present the programs (e.g. Project Family Map of Salem State College, DSS statewide meetings, Healthy Start). 	
<p>ICPC</p> <ul style="list-style-type: none"> • Continue to update the Emergency Medical Services for Children website. • Finalize the Injury Prevention and Control Program website. 	
<p>SBHC</p> <ul style="list-style-type: none"> • In 2001, the Bureau is providing funding to support School-Based Health Center projects in 3 rural school districts. 	
<p>State Office of Rural Health <i>Service Availability in Rural Areas</i></p> <ul style="list-style-type: none"> • Disseminate information about MCH resources, funding opportunities, new rural health models, and emerging rural MCH policy issues to a vast network of rural providers, community groups, and local health officials • Provide financial support to Massachusetts rural conferences and ensure the participation of rural providers and coalitions in annual statewide MCH Conferences. • Continue to assess needs, provide technical assistance, support the development of new MCH programs in rural areas, and build capacity for an enhanced supportive system for rural providers • Continue to provide state level leadership for addressing rural MCH issues and assist with efforts to recruit and retain rural MCH providers • Continue to work with the MDPH Family Planning Program to assess needs, identify appropriate service models and opportunities that will extend family planning services into the underserved remote and rural areas of the state. • Collaborate with the MDPH Office of School Health to support the role of the school nurse as a key health resource in rural communities and promote the development of enhanced school health services and school based health centers in rural areas. • Coordinate the Rural Hospital Flexibility Program with the aim of stabilizing small rural hospitals, increasing access to and improving coordination of health care services, developing more comprehensive and accessible health care networks, improving EMS, and ensuring quality of care. • Convene a statewide conference for rural providers on the benefits and uses of telehealth, rural funding opportunities, and key resources in order to enhance rural health networks and increase access to additional services. • Work to increase public knowledge of MCH services in rural communities. 	
<p>Combined Primary Care Program</p> <ul style="list-style-type: none"> • New funding, made available through the state tobacco settlement, was awarded to Community Health Centers for a variety of activities that focus on infrastructure, outreach, health education, interpreter services, transportation, staff education and training opportunities, community-based programs or activities that will address health disparities, needs and gaps, and oral health. 	

Other Activities Not Discussed under Specific Performance Measures or Priority Needs

Programs/Activities	Pyramid
<p>School Health Services</p> <ul style="list-style-type: none"> • Collaboration with the Massachusetts Committee of School Physicians (AAP and MMS representation) 	
<p>MCH Health Education</p> <ul style="list-style-type: none"> • Provide expanded technical assistance to DPH programs in the development and assessment of health education materials and methods that are appropriate for audiences with limited literacy skills. Participate in Massachusetts Family Literacy Consortium, a U.S.D.O.E.-funded statewide collaboration to strengthen family literacy, which will improve health outcomes and promote prevention through joint activities such as training, public awareness campaigns, and resource development and sharing. 	

4.2 Other Program Activities

Toll-free Hotlines (see ERP Form 9 also)

The **Maternal Child Health Family Resource Line** has a single statewide 800 number (**1-800-531-2229**) which is routed automatically to the appropriate DPH regional office to assure a local response. The resource line is staffed during normal working hours with regionally-based multi-cultural specialists speaking 10 different languages, so that consumers can receive assistance with health care access in their spoken language. Staff provide support, information, referral and advocacy addressing all aspects of the health access continuum, with a specific focus on maternal and child health populations, and on the Healthy Start, CMSP, MassHealth, other child health insurance, FIRSTLink and FOR Families programs. Assistance ranges from eligibility information, enrollment assistance, follow-up, promotion of preventive health care utilization, risk and needs screening, and linkages to primary and preventive health care, home visiting, and other community-based support services.

FIRSTLink uses the MCH Family Resource Line as the first point of contact for parents seeking information about FIRSTLink home visits and community resources. While at-risk newborns and families are referred immediately to a home visit provider, families without identified risk factors are sent a post natal packet encouraging them to call the 800 number for more information or to schedule a home visit. The health access specialists answering these calls conduct a telephone intake to identify particular concerns of the parent and screen for immediate needs (food, housing domestic violence concerns). Referrals are then made to appropriate resources.

With the ever-increasing complexity of the health care environment, the resource line facilitated over 80,000 calls (incoming and outgoing) in FY99. Health Access Line staff work closely with WIC, the Division for Special Needs, and MassHealth to assure complete, up-to-date listings of all MassHealth providers. The addition of FIRSTLink brought a new electronic database of resource information on a wide range of health care, social service, and other community based supports and resources, including domestic violence, food stamps, housing, child care and many others. The database is both searchable and can be easily updated. It is located on a central server so that all regional office staff can access the resource information as needed.

The statewide **Family TIES hotline for CSHCN (1-800-905-TIES)** maintained by the Division for Special Health Needs is also a “**smart-line**” with a single 800-number statewide. Using the technology of “enhanced call routing,” it can identify the in-state caller’s geographic location and route the call to the appropriate one of six regional offices. This line connects callers to the Division’s regional Family TIES parent coordinators, who serve as the source of information and referral to both statewide and regional services and providers. The Family TIES project also serves as the Central Directory for services that is

required under Part C of the IDEA. This provides the opportunity for an immediate parent to parent connection and the provision of more individualized information and linkage to the appropriate supports. Due to increased publicity in Early Intervention materials and elsewhere, calls to this 800-line increased by 250% from FY98 to FY99. Referrals to Early Intervention from these calls more than doubled.

In addition, the Bureau maintains an "**SSI and Public Benefits for CSHCN**" toll-free number, (**1-800-882-1435**), which handles calls, from both parents and professionals, in three major categories:

- SSI and other public benefits information and technical assistance for parents, agencies, hospital staff, and professionals regarding cash assistance and health care coverage for children with special health care needs;
- Requests for *Directions: Resources for My Child's Care*, a manual for families with children with special health care needs enrolled in MassHealth Managed Care.
- Calls regarding Special Medical Fund programs and the Family Support Program.

The Bureau also operates or helps fund a number of other statewide hotlines which are widely used and listed on the MDPH website:

- The **WIC Program** statewide 800 line (**1-800-WIC-1007**) operates Monday through Friday 8:00 a.m. to 5:00 p.m. for information on obtaining WIC services.
- The **Regional Center for Poison Control and Prevention** operates a toll-free, twenty-four hour number (**1-800-682-9211**) for poisoning emergencies and poison information. This line, previously serving only Massachusetts, now serves both Massachusetts and Rhode Island.
- The **Massachusetts SIDS Center** operates a 24-hour toll-free hotline (**1-800-641-7437**) for SIDS information and crisis counseling and for requests for educational material.
- The **Coordinated Food Stamp Outreach Program** maintains a statewide toll-free number (**1-800-645-8333**) called the FoodSource Hotline.
- The **Injury Prevention and Control Program** operates a statewide 800 line (**1-800-CAR-SAFE**) during normal business hours for information on educational programs and materials, safety laws, and general technical assistance.
- **Llámanos** is a statewide toll-free 24-hour Spanish-language sexual assault hotline funded by the Sexual Assault Prevention and Survivor Support program (SAPSS). The hotline provides support, information, counseling, and referrals for Spanish-speaking survivors and their significant others. In addition, it provides technical assistance, training, and outreach to improve the quality, accessibility, and relevance of sexual assault prevention and survivor services for Latino survivors and their communities. English-language hotlines are also maintained by SAPSS programs.

- The **Massachusetts Osteoporosis Awareness Program** operates a statewide 800 number (**1-800-95BONES**) with information on preventing osteoporosis, including healthy eating ideas, increasing calcium in the diet, and physical fitness.

Information on our extensive involvement with the state Medicaid Agency regarding EPSDT and outreach and presumptive eligibility to enroll eligible clients and with other state agencies dealing with education, SSI, and rehabilitation services are incorporated into section 4.1 as they relate to a number of performance measures and state priorities; they are also summarized in Section 1.5.2. The Title V agency directly administers the state WIC Program, Part C of IDEA, and state family planning programs.

4.3 Public Input

A public hearing will be held in September 2000 in Framingham, to allow formal public comment on the four federal block grants administered in full or in part by the Department of Public Health: Maternal and Child Health Block Grant; Alcohol, Drug Abuse and Mental Health Services Block Grant; Preventive Health and Health Services Block Grant; and the Women, Infants and Children (WIC) State Plan. Notices are being mailed to organizations and individuals concerned with maternal and child health who are encouraged to attend and present oral and/or written comments on the activities of the Bureau of Family and Community Health. Differing timelines for submission of the four applications make this date the most practical. We plan to make the Application / Annual Report available to the public through the MDPH Home Page (as well as through the new MCHB-plans for making the full text documents available on the web along with TVIS). Additional comments will be solicited through that mechanism. We will be circulating the document widely to vendors, advocates, and MCH/CSHCN professionals.

The BFCH and MDPH staff also encourage input and comment throughout the year as well. Our extensive participation in numerous advisory committees, community coalitions, CHNA teams, and similar groups assure on-going input from the public and ready access to the state Title V program by many people and organizations.

4.4 Technical Assistance

Massachusetts plans to use its technical assistance funds to sponsor the third New England Regional Poison Control Center and Title V meeting in the mid-spring of 2001. This meeting will focus on sharing of best practices, identification of areas for collaboration between MCH programs and Poison control Centers, and further possible regionalized efforts for collaboration and to strengthen the operations of each Center. The past two meetings have provided an opportunity for the Poison Control Centers, MCH and CSHCN staff to meet with not only their state programs but to understand what is happening in other New England states. Two results of these meeting are increased networking in relation to the

establishment of emergency plans and for education efforts. In Rhode Island and Massachusetts the Poison Control Program is funded through the Title V agency. In the other New England states the title V programs have limited to no interaction with their state Poison Control Centers. This meeting provides a real opportunity for network at both the state and regional level.